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INTUITION V. THE EGO IMAGE

BY ERIC BERNE, M.D.

I. The Problem

An eight-year-old boy, vacationing at a ranch in his cowboy suit, helped the hired man unsaddle a horse. When they were finished, the hired man said: "Thanks, cowpoke!" To which his assistant answered: "I'm not really a cowpoke, I'm just a little boy."

This story epitomizes something which has to be understood in regard to a patient (or anyone else) to maintain rational insight into the interpersonal relationship when that is desirable. The patient who told it remarked: "That's just the way I feel. Sometimes I feel that I'm not really a lawyer, I'm just a little boy." Everything that was said to this patient was overheard by both people: the adult lawyer and the inner little boy. To anticipate the effect of an intervention, therefore, it is necessary to know not only what kind of adult one is talking to, but also what kind of little boy. This man came from Nevada, and he had a special system for avoiding depression when he was gambling. If he won, he would feel duly elated. If he lost, say $50, he would tell himself: "I was prepared to lose $100 tonight and I've only lost $50, so I'm really $50 ahead and I needn't be upset." Often, especially if he was winning, he would take a shower, after visiting one casino, before he visited another, as if to wash away his guilt so he could feel "lucky" once more.

It is evident that there were two kinds of arithmetic employed here: When he was winning, that of a rational adult; when he was losing, that of a child with an archaic method of handling reality (denial). The taking of the shower represented a lack of confidence on the part of the "child." He did not trust the rational, well-thought-out, and rather effective gambling system of the "adult." The shower was part of a primitive, autistic contract the "child" made with the powers of gambling, in order to obtain license to win again.*

It was difficult to deal effectively with this patient without

*The analysis of this behavior led directly into the areas explored by Bergler (Ref. 1) in his study of the psychology of gamblers, and does not concern the present discussion.

understanding these two different aspects of his personality. They were both conscious and both belonged to the ego system. One part of his personality faced reality as a whole, the other took it bit by bit and, by convenient manipulation, managed to find comfort in distressing situations, and anxiety in comforting ones. One part handled reality rationally, the other exploited it in an archaic way. There was no immediate question of the conscious versus the unconscious, or of ego versus id, in the sense of parapraxis or ego-dystonic behavior. Each approach made good sense in its own way: One was appropriate for the mature ego, the other was appropriate for a more primitive one. Conscious and unconscious, ego and id, were all involved somehow; but what was observed directly and what was most apparent to the patient and to the observer was the existence of two different conscious ego states: one that of an adult, the other that of a child.*

II. Clinical Significance

Now—to leave the corral and the casino and go to the couch—the same division into at least two ego states can be observed more or less easily, in every patient. Ned, the lawyer, was a sexually confused man who used to make remarks in his social life like the following: "Us girls have got to be careful not to drink too much." After he had been in therapy for some time and was becoming acquainted with his two ego states, he reported that he had had the following unspoken thought at a party: "If I were a girl (but I'm not a girl) I wouldn't drink too much." He understood what this meant. In the old days, the "child" had prompted the "adult" to say: "Us girls..." Now the "adult" objected to the promptings of the "child" in two ways: "I'm not a girl," and, "I don't intend to make remarks about it aloud in any case."

In this example, the patient conveniently offered material which indicated what was going on and what kind of "child" had to be dealt with. In other cases, the situation is more obscure, and it requires a considerable degree of clinical intuition to make the psychological dissection required to separate the "child" from the "adult."

In previous publications, the writer has discussed the nature of intuitive processes,[2] their functions in diagnosis[3] and in the

*This case has been discussed in more detail elsewhere (Ref. 12).

understanding of latent communications,[4] and their phenomenological reality as primal images.[5] The present communication is intended to bring these processes into focus, as constituting a specific feature in clinical psychotherapy. A similar process of bringing into focus was undertaken in considering "primal images," the therapist's perception of the mode and zone of the patient's instinctual strivings as aroused in the therapeutic situation and directed toward the therapist. The present discussion will be of "ego images," which are specific perceptions of the patient's active archaic ego state in relation to the people around him. An illustration may help to clarify this.

Certain patients appear in practice who may be characterized at the outset as "severe latent homosexuals," or "latent paranoid schizophrenics." The primal image activated by such a patient may give rise to the primal judgment: "This man is concerned about buggery." That means that his instinctual position in relation to the therapist is an anal receptive one; he symbolically turns or avoids turning his buttocks. This is valuable information and may have considerable predictive usefulness as a guide over a long-term course of therapy. But its value is limited in the initial situation and in various complex digressions which may arise. The "ego image" complements the ultimate orientation given by the primal image. It offers a much more useful guide in the preliminary phases of treatment and in diluted forms of treatment, particularly in helping avoid unnecessary hostile responses whose significance might be clouded by labelling them "unexpected transference reactions." The same man who evokes the primal judgment: "He is concerned about buggery," may also elicit the following intuitive impression: "This man feels as though he were a very young child, standing naked and sexually excited before a group of his elders, blushing furiously and writhing with almost unbearable embarrassment." This is an image of the patient's ego state, and hence may be called an "ego image," just as the image activated by his instinctual strivings may be called a "primal image."

The primal image, then, refers to an instinctual orientation; the ego image refers to an ego state. It is difficult to apply usefully the first piece of information, "This man is concerned about buggery." At the beginning, all one can do is refrain from threat-

ening him, either actually or symbolically; at the end, it becomes a highly technical and complex matter to use the information advantageously and therapeutically. The second message is more useful: "He is writhing inwardly with almost unbearable embarrassment." From the moment this message is perceived, it can be profitably applied in the immediate situation.

Doubts as to proper technique can be resolved by asking one's self: "What would I say or do if a three-year-old child who was writhing with embarrassment behaved the way this patient is doing?" This is a much easier question to answer than: "What do you do if a passive anal homosexual behaves in this way?" Furthermore, it seems simpler to detect and control countertransference tendencies toward an embarrassed three-year-old child than toward a passive homosexual adult, if only because the former is for most people a more congenial figure. Both the primal image and the ego image represent aspects of the "child," and together they form a useful guide at all stages of therapy.

Ordinarily, of course, one does not discuss such intuitions with patients until the footing is secure, if at all; but the therapist keeps them continuously in mind, and they control his behavior. Diana, a young housewife-student who was perceived in just the squirming way described, had had two psychotic breaks requiring hospitalization during a five-year period (1946-1951): one before she came to the therapist and the second a year after she had interrupted therapy. During her first therapeutic period, she was treated according to the principle: "This is a woman with strong homosexual conflicts and strong anal receptive strivings." For example, her heterosexual genital attitudes were encouraged; but this was not enough.

In the five years after the therapist focused on perception of her ego state (1951-1956), she required no further hospitalization. Furthermore, when she had broken down in 1949 after leaving therapy, the therapist had been involved in her delusions as a hostile conspirator. During the second phase, when she became disturbed on two occasions after discontinuing her treatment temporarily there were two differences from the 1949 break: First, the therapist was cast in the role of a beneficent conspirator so that she felt safe, because he was arranging for her to be safe at all times; and, second, her mature ego (the "adult") had been

strengthened sufficiently so that she did not break down, and so that she recognized her troublesome feelings as delusions, the revival of an archaic ego state (Cf. Federn[6]). As a result, she was able to carry on her work and her studies efficiently enough to keep her household going and to pass her examinations with a good grade, even during periods when she was engaged in an acute struggle with her paranoia. And there was something much more specific at work here than a mere orthodox shift from "id therapy" to "ego therapy."

In Diana's case, it became possible to investigate the accuracy of the intuitive ego image. After being treated once weekly for two years according to the principle, "Remember she is a child, writhing with embarrassment," rather than, "Remember the homosexual and anal conflicts," she was introduced to a therapy group. After a year in the group, it became possible to mention to her how the therapist perceived her ego state. A couple of weeks later she reported that she had been much impressed by this conception of herself and had given it a good deal of thought. The therapist had gained his insight one day by carefully observing her manner in the office, and thus far had no historical grounds for his intuition. She now offered the following material:

"I don't remember this myself but my mother told me about it. I was playing in our back yard. For some reason my diaper was off and I was naked. A group of men were watching me over the fence and laughing. My mother came out to see what it was all about. She got very embarrassed when she saw what was happening and hustled me into the house. I can imagine how embarrassed she was, because she still undresses behind a screen."

This story, which is most likely a second-hand account of a repressed screen-memory, was the first evidence that the ego image had a historical basis. Yet the patient's response to the therapist's revised attitude had already indicated that his intuition was correct.* The therapist, on his part, had had enough confidence in his intuition throughout to adhere to it, even when this made difficulties with the other members of the therapy group because of alleged "favoritism." But by treating each member of

*At the time of going to press, the patient has been married for six months and is functioning happily as a housewife.

the group according to the indications offered by his respective ego image, these difficulties were overcome. The real problem arose with members of whom he was unable to obtain clear ego images.

III. A Clinical Example

One may now observe in some detail how the attainment of a clear ego image improved a rather chaotic and unfavorable therapeutic situation. The case concerns a 40-year-old woman in whose case the primal image was clear enough from the beginning: She was wallowing in feces and was involved in a powerful conflict about how far she could go in defecating, with generosity as well as with malice, all over the therapist. The difficulty was, however, that at the time the treatment began, the therapist did not know about ego images; or in more ordinary terms, did not perceive the patient's ego state concretely enough, although it was sufficiently clear in an academic, inferential way.

This patient, Emily, was referred for treatment of severe, frequent, and long-lasting hemicrania, with scotomata and sometimes vomiting. She had spent a great deal of time during the preceding 15 years looking for and trying various remedies without relief, including a year of psychotherapy three times a week. For cogent reasons, she could only be seen regularly twice a week by the writer—occasionally three times weekly—hardly an encouraging program for such a refractory case. Nevertheless, after three years her condition was considerably ameliorated—the headaches rarely occurred—and she reported that she got along better in several types of situations.

For the first two years, however, the improvement had been superficial, unstable, and sporadic, because of lack of insight on both sides. It was only after the therapist obtained a clear-cut ego image that the course of therapy could be controlled with some understanding and precision.

This patient showed many depressive symptoms: weeping spells, suicidal fantasies, sensitiveness with resentment, and depression itself. She was tyrannically self-depreciating, guilt-ridden, passively aggressive, and masochistic. Her defenses were weak, spotty, and poorly organized: There was obsessive cleanliness combined with untidiness; there was a strong but inefficient effort to appear cultured and well-bred; and she was stubborn, yet panicky.

Demands for sympathy from her husband were easily smashed. There was sporadic alcoholism, and a continual quest for new medications, which she did not take regularly. She made aggressive threats, coupled with abject compliance; and she exhibited righteousness, combined with crafty deceptiveness. If these trends had been firmly established, they could have been dealt with, but they lacked stability and integration. The picture was not so "hard" as it sounds. The whole defensive system was "soft" to the point of mushiness, giving the clinical impression that it could not be dealt with, but only wallowed in.

At the slightest sign of danger, Emily relinquished one defense and sank into another. Interpretation failed, because she could see it coming. She experienced it as "name-calling," and would obviate it by calling herself names first. If interpretations were withheld, she felt lonely, neglected, and suicidal. "Support"—if she did not succeed in finding criticism in it—made her feel guilty and more depressed.

During this phase, the patient was much more satisfied with her progress than the therapist was. She did not want to transfer to another psychotherapist or another form of treatment.

The behavior of the therapist during this period was guided to some extent by an academic, inferential and rather stereotyped "ego model," which remained unformulated and preconscious. This model characterized the patient in a banal, barren, and obvious way in such terms as vulnerable, apprehensive, conventional—seeking justification for resentment, self-pity, and self-castigation. This perceptual skeleton, fleshless though it was, had undoubtedly exerted a helpful controlling influence on whatever progress had been made. But evidently its value as the basis for a live therapy was low, even if a new bone could be added to the frame from time to time.

Then one day she remarked: "I was a bloody mess when I was born and a disappointment to my parents because I was a girl." This report, typical for this kind of patient, was of little practical value. But later in the hour she added: "My mother told me that I disgusted her when I was wet, and she hated to pick me up. But she said my uncle Charlie would cuddle me even when I was dripping. He didn't mind picking me up at all. She

used to say to him: 'How can you hold her when she's in that disgusting condition?"

This was probably a second-hand account of a repressed screen-memory, as in the case, noted before, of Diana's nakedness. It immediately brought the whole situation into better focus. It told the therapist how Emily felt, and it told him how he must behave. Things began to go more smoothly. Everything was now more understandable, controllable, and predictable; that is, the treatment proceeded with only the usual errors and oversights on the part of the therapist. His groping and his feeling of inadequacy gave way to a well-oriented therapeutic plan.

The descriptive ego model was now replaced by a substantial ego image. Emily was no longer a set of verbal concepts but a clearly pictured personality. She was an infant with a dripping diaper, shrinking from her mother's disgust and tyrannical castigation, and looking for an uncle to hold her as she was. The therapist had only to be that uncle, and the situation would improve. He was, and it did. Counter-transference reactions became simpler to detect and avert. Transference reactions became easier to understand, to predict, to control, and to work with.

The therapist could now ask himself: "How does she expect this uncle to behave?" in order to know what to do and what not to do; and, "What does she want from this uncle?" in order to understand what the patient was doing in the treatment. There were, of course, many aspects to be tested. The ego image had to be refined in the crucible of experience. After a few months, the situation could be understood as follows: "The uncle who is holding this little wet infant must avoid a great many things, such as letting on that he knows she is wet. He must make it clear that he will hold her even when her mother will not—and that he will do so without betraying her, scolding her, seducing her. If he fulfills these conditions, she will gossip to him about all sorts of things and even tell him secrets more and more terrible that she could never tell anyone else."

This ego image was not mentioned to the patient, for that might have damaged its usefulness. Her account of the Uncle Charlie incident was allowed to pass without comment, and the therapist did not refer to it again. There was plenty of other

material available for the exploration of her urinary problems. In the ensuing months, her headaches lessened in frequency, intensity, and duration, she began to hold her own with other people, and was able to talk more and more freely about her early anal conflicts and even about her current anal masturbation; these were all noteworthy accomplishments for her. All this, of course, was related to "transference improvement."

It will be noted that this approach referred entirely to her ego state and took no account of her id strivings in relation to this uncle. It was clear, however, that sooner or later her desire to urinate and defecate on the uncle would have to be broached; that is, the ego image as a guide to therapeutic technique would have to give way before the primal image. The ego image served its function in the transitional stage between establishing a clear relationship and beginning progressive, well-oriented therapy, and one could always fall back on it in times of stress.

To clarify the situation in review: The ego image served as a technical guide in approaching the suggestive picture presented by the primal image. Three years of experience indicated that the only person to whom she could possibly reveal her wallowing in feces, her coprophilia, and her soiling impulses, was someone who treated her like an uncle; and then only when she was securely assured of his benevolent fidelity. In the hands of two different therapists, no other technique had succeeded with this patient. Nearly everybody agrees that special techniques are necessary in order to do analytic work with patients who are basically close to psychosis. On the other hand, this present technique was not a corrective emotional experience, in the sense of Alexander. It was a repetition of a good infantile experience.

A new phase began when the patient moved decisively from the urinary to the anal sphere. The old ego image then lost its value, and the therapist once more became uncertain of his position. He had to fall back again for guidance on an academic, descriptive ego model. An incident when the patient was put out on the doorstep for soiling her bed was not of much value since it merely indicated what was easy to see anyway, that she was afraid of being thrown out if she had "dirty" thoughts. This episode did not distinguish her as an idiosyncratic individual in relationship with other idiosyncratic individuals, as the Uncle

Charlie situation did. It gave no clear, substantial picture of her ego state and, therefore, could not serve as the basis for an ego image. Because no ego image came to light to serve as a guide during this phase, the third stage of her treatment proceeded in a less coherent way.

Incidentally, the accuracy of the primal image, in which she was defecating all over the therapist, was confirmed during the later phase. On two occasions when she had diarrhea, she soiled her husband slightly during intercourse just when she reached orgasm. She described her feelings as a mixture of great pleasure and great disgust. (The final therapeutic outcome of this case is not determined yet.)

IV. Ego Model, Ego Symbol, and Image

From the foregoing, it can be seen that the ego image comes to life with varying degrees of difficulty with different patients. Sometimes it never comes to life at all. Experience up to this point indicates that in general it offers itself most easily in cases of latent schizophrenia and least readily in cases of complicated character neuroses. The patient himself is probably rarely, if ever, aware of it, or at least of its significance, since in verified cases it seems to be based on second-hand accounts of repressed screen memories; and such things seem of little importance to the patient, because the affect is not accessible to him. But increasing experience gives the therapist more and more hints as to where to look in various types of cases. Such experience is worth cultivating, since, as Emily's case demonstrates, the attainment of a clear ego image in the therapist's mind may be crucial for the progress of the therapy, especially in regard to time.

How is the ego image picked out? This is a topic which is difficult to clarify. In the case of latent paranoid schizophrenics, as well as in other diagnostic categories if the same kind of archaic embarrassment is present, the patient's squirming may be observed in a larval form, and a question about erythrophobia may confirm the perception of the "child's" ego state. In a case such as Emily's, where the therapist has no precedent, it is simply the fact that all sorts of vague impressions and academic conceptions regarding the patient seem to crystallize, come to life, and become highly

intelligible when the right note is struck. Evidently the therapist's intuitive readiness has a great deal to do with picking out of the enormous mass of first-hand and second-hand memories precisely the one which can serve as a beacon to guide him at every step in the right direction. Beyond this, little can be said now; the explanation must await further studies of the intuitive process itself.

In practice, if he is fortunate, the therapist may find himself at a certain moment holding in his mind an image by means of which he can evaluate his own reactions, sort out therapeutic and contratherapeutic attitudes, predict with considerable success how the patient will react to what he says, and understand why she is reacting in a certain way to what he has said. In Emily's case, for example, the therapist found it wise to reject all "unavuncular" reactions on his part and act only upon "avuncular" ones; while at the same time he tried to avoid obviously avuncular statements, because these might sound seductive or too revealing and so spoil the therapeutic situation. At a later phase, the ego image loses its usefulness, and the therapist is once more on his own, with only academic knowledge, clinical experience, and the primal image to guide him; but now he is on a more secure footing than at the start, and the patient may tolerate a good deal of misjudgment on his part—a relaxing and encouraging situation for an average therapist.

If a convincing ego image is not forthcoming in a given case, the therapist need not feel lost, since there are two worthwhile substitutes. The first is the "ego model" already referred to. This is a descriptive perception of the patient, an additive rather than a holistic one, an atomistic series of propositions rather than a gestalt. The ego model came to perhaps its highest flower in the work of Eugen Kahn,[7] with his "heuristic system of psychopathies according to the clinico-descriptive method," resulting in an exquisitely sensitive and detailed set of such models. Kahn later attributed to each of these types its own "way of experiencing," thus adding to the usefulness of his descriptions.

The second type of substitute may be called an "ego symbol." This is intermediate between an ego model and an ego image. Its nature may be illustrated briefly by two examples.

1. A young woman gave at the first interview with the therapist a strong impression of being extremely frightened underneath,

although on the surface she presented herself rather well as a sophisticated, competent, and well-integrated person. Unhappily, the history tended to confirm the therapist's impression of intense underlying anxiety. But for two months in treatment she maintained her good front. Then one day she came in with a clipping from a magazine, an advertisement for frozen chicken. The drawing depicted a plucked chicken lying on a couch, apparently comfortable and relaxed, waiting cheerfully to be cooked and eaten. This picture reproduced the patient's attitude on the couch so accurately and made her underlying feelings, even her resigned cheerfulness, so clear that both patient and therapist burst out laughing. From that time on, the therapist treated her with the kind of consideration she would be entitled to if she were really in the unfortunate chicken's situation, and the results were gratifying. (This may be characterized as a "counter-cannibalistic" attitude on the part of the therapist, in the face of what now appeared to be provocative behavior from the patient.) This picture was not so good a guide as a more personal ego image but it served its purpose well as a symbol of how the patient felt and as a guide in therapeutic technique.

2. An intelligent, imaginative, and socially productive schizoid man gave a large number of responses on his initial Rorschach examination. Two of these in particular attracted the therapist's attention: "a worm" and "a dried-up insect." The therapist adopted these tentatively as ego symbols and from the beginning treated the patient with the kind of consideration due to one who felt no more worthy than a worm and no more alive than a dried-up insect. Of course the therapist gave the patient no hint of his thoughts on the matter. Shortly afterward the patient spontaneously began to interlard his productions with occasional associations about worms and dried-up insects, usually in connection with incidents where he was treated in a humiliating or neglectful way. At first, everything the therapist said and did was guided by the principle: "Would this be therapeutic if it were applied to a worm or a dried-up insect?" At times, it was possible to judge even which ego symbol applied at a given moment; during one hour, it would be necessary to do "worm therapy," and a few hours later, "dried-up insect therapy." The reader may well ask, "What is worm therapy?" and, "What is

dried-up insect therapy?" These are questions to which verbal answers cannot be formulated. Nevertheless, one intuitively knows how to avoid hurting humiliated worms and neglected insects and how to help them on their evolutionary way toward humanity. It is a little different, for example, from helping a plucked chicken on her way to becoming an effective woman.

In the writer's experience, one of the chief clinical values of a Rorschach report is that it may yield important symbolic information regarding the patient's ego state; such information may serve as a significant guide in therapeutic technique and may be particularly welcome if a good ego image is not forthcoming.

Interestingly enough, in the two cases cited, the ego symbols appeared spontaneously in the patients' associations during treatment but did not occur in their dreams. Neither did the "squirming child" of Diana or the "dripping infant" of Emily appear in those patients' dreams.

On the theoretical side, the ego model is descriptive. The ego symbol is related to Silberer's functional phenomenon,[8] and can be discussed in terms of Jones' ideas about symbols.[9] The ego image finds its theoretical basis in Federn's ideas, summarized as follows by Weiss: "That ego configurations of former age levels are maintained in potential existence within one's personality is experimentally proven, since they can be re-cathected directly under special conditions; for instance, in hypnosis, in dreams, and in psychosis. In fact, Federn recognized that every morning, upon awakening, the ego undergoes a rapid repetition of its development from birth. He introduced a new term to indicate this process, *orthriogenesis*."[10] What is maintained by Federn is that many neurotics and latent psychotics are fixated, not only libidinally but also in their ego states. (From the descriptive point of view, this is also Kahn's "way of experiencing.") The ego image thus functions as an intuitively selected paradigm of the patient's ego fixation, which, according to Federn's terminology, would constitute "incomplete orthriogenesis." The ego symbol and the ego model are less plastic representations of the same thing. Therapy in this light then involves completing the orthriogenesis; and, as this ego therapy proceeds, the libidinal fixations can also be dealt with according to the indications.

One more item is worth considering: the application of the

ego image and the primal image to everyday life. One can infer that the kinematic basis of interpersonal relationships is mutual intuitive understanding through partial ego images and primal images even though these may never become conscious. That is, any two people in any kind of ongoing relationship behave *as though* they were acting in accordance with ego images and primal images (cf. Ref. 3.); and the more congenial or complementary these images, the more chance that the relationship will survive certain kinds of reality difficulties—or so it seems. In this connection, the ego image is what seems to be related to and worked with in everyday life; while the primal image shows what is strongly or ambivalently defended against—that is, what kind of seduction is to be feared or ambivalently permitted. Emily's friends accept her and listen to her, and she loves them for it, just as she did her uncle; but they sidestep her symbolic attempts to defecate upon them. Very likely there is some competition in her circle in the latter sphere. Sensible people protect latent paranoid schizophrenics from embarrassment in accordance with the ego image, but they avoid unwholesome entanglements with them, warned by the primal image, even if, as is usually the case, both images remain unconscious. If the "sensible people" fail in either respect, the relationship will either not proceed well or will become extraordinarily complicated and no longer a matter of everyday life. Similar considerations apply to relationships between more stable people.

V. Therapeutic Application

To return to the original example of Ned, the gambling lawyer, where there seemed to be a "child" and an "adult," how does one treat such a person? If one talks sensibly, the "adult" will understand, but the "child" will subject what is said to his own peculiar rules of logic. If one talks babytalk, both the "child" and the "adult" will justifiably become indignant. Both croupiers and psychiatrists have to know this. Such a person must be spoken to like an adult but treated like a child. To succeed in this, it is necessary to know what kind of child one is dealing with. This does not mean giving in to the child, but does mean "treating" the child in the clinical sense. (Cf. Ref. 12.)

In fact, careful observation indicates that this therapeutic prin-

ciple applies to all patients. The colleague who first helped to clarify this was a pediatrician. It soon appeared that the psychiatrist's professional position was similar to his, something like that, in fact, of a pediatrician who has to treat a serious family problem in a one-room cabin in the middle of winter. Since neither the mother nor the child can be sent out of the room, everything that is said to the mother will be overheard and scanned by the anxiously alert child who is confusedly fighting with all his strength for emotional survival; and everything that is said to the child will fall on the defensive ears of the mother. Under these conditions, therapeutic control can only be maintained by an adequate knowledge of the psychology of both the individual adult and the individual child. It is not enough to say or do what is appropriate only for the mother; if the child is alarmed by it, the situation is not improved or will deteriorate; nor is it enough to say only what is appropriate for the child, for if the mother is not reassured by it, she may become increasingly defensive.

In the psychiatric situation, the adult and the child are contained in the same individual. It is true that the "child" can be cowed sometimes by an authoritative or threatening attitude (there are indications that shock treatment may fall into this class), or the "adult" can be "sent out of the room" by the use of certain pharmacological and other procedures (narcoanalysis and hypnosis), but sooner or later the decommissioned part of the personality returns, and then the fat is in the fire. In rational psychotherapy, it is necessary to deal with both simultaneously. The "adult" responds to the rationality (by definition, so to speak) and does not constitute a problem. The "child" responds to the therapy, and it is here that the therapist's experience, knowledge, attitude, and intuition have their value. The most effective way to control the situation is by means of a valid ego image. It has already been indicated that neurotics are most difficult to work with in this respect, since the ego image does not seem to emerge so readily as in other patients, and the therapist may have to be content with an ego model or an ego symbol. It is particularly in the most difficult classes of patients, such as psychopaths, "acting-outers," schizoids, latent schizophrenics, and the mentally retarded, that an ego image is most likely to be

accessible. In other words, the ego image is easiest to attain just in those cases where it is most needed and where it will do the most good. In any case, every psychiatrist has to function as a child-psychiatrist, even if his practice is confined to adults.

The therapist who works with ego images for a year or two will eventually run into a complication. He will find that there are not two, but several, ego states that have to be taken into account for more precise work. While the child-adult framework gives excellent results in many types of cases, it is possible to go farther. But this subject belongs in the field of psychotherapy and is no longer something which pertains primarily to the problem of intuition.*

In the present series of studies concerned with intuition, covering a period of 10 years,[2-5] a bridge has been built from "guessing games" about soldiers' occupations over to the intuitive understanding of patients and the use of intuition as a psychotherapeutic tool in a specific framework. The clinical examples given show that perhaps none of the conclusions are new; but something may have been learned through reaching them by a rather unusual approach.

Summary

1. The intuitive understanding of patients is phenomenologically manifested in two kinds of images: primal images, which refer to predominant modes and zones of instinctual striving; and ego images, which refer to fixations in the patient's ego state.

2. Ego images, in the writer's experience, are most readily forthcoming in cases of latent psychosis.

3. Ego images, ego symbols, and ego models are distinguished as guiding influences in therapy; each of them is useful to a certain degree in understanding a patient's regressive ego state and the therapist's reaction to it. Ego images represent Federn's approach, ego symbols Silberer's, and ego models Kahn's.

4. Ego images and primal images also have their influence on the interpersonal relationships of everyday life.

5. Ego images help the therapist to clearly distinguish archaic ego functioning from mature ego functioning. For convenience,

*Since this paper was written, a subsequent paper has been published, dealing with the elaboration of these ideas as applied to psychotherapy (Ref. 12).

these aspects of functioning are called the "child" and the "adult" in the patient.

6. The psychiatrist's position is similar to that of a pediatrician who cannot send either the mother or the child out of the room. Thus every psychotherapist must function simultaneously as a child-therapist and an adult-therapist, even if his practice is confined to adults.

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AUTISTIC AND SYMBIOTIC DISORDERS IN THREE BLIND CHILDREN*

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There is an increasing awareness, the writers believe, of psychological disturbance in blind children, as evidenced by the greater number of referrals to child psychiatry clinics, as well as by the concern among nursery school teachers in particular, over the withdrawn or disturbed behavior in a significant minority of the children in their groups. Visits to nursery groups afforded a ready opportunity to see these withdrawn, "unrelated" children off in a corner, in some private activity of their own. The present study was stimulated by an intrinsic interest in the psychopathology involved in the condition of these children, as well as by a knowledge of the large number of blind children now entering school—in spite of the rapid decline of retrolental fibroplasia in the newborn in the past several years.

General Considerations

The study concerns three blind children who were referred to the Child Psychiatry Clinic at Roosevelt Hospital, New York City. These children showed strikingly similar psychopathologic behavior, as well as common trends in the relationships to their parents. The description of their histories, diagnoses and therapy is submitted with the hope of clarifying the difficult problems involved in the autistic and symbiotic disorders of blind children, and in the hope of calling attention to the need, as yet largely unmet, for early therapeutic intervention in such cases.

The term "autism" was coined by Bleuler in his classical study of the schizophrenias, to describe a kind of active turning-away from the external world. In a report of this study, Bleuler[1] says "Autistic thinking may be a fleeting episode of a few seconds duration, or it may fill a life and entirely replace reality, as in demented schizophrenics who live in their dreams, allowing themselves to be dressed and fed. Between these two extremes, we find all shades of transitions. The autistic world may be a continuous whole or may consist only of isolated and fleeting thoughts, illusions or delusions that interrupt realistic thinking from time to

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time." Bleuler made a distinction between "normal" autism, such as daydreaming, night dreams, and children's play, and pathologic autism as seen in much of the behavior of schizophrenics. Kanner[2] used the term "autistic" more recently to describe a group of children who seemed to show no feeling for persons, but rather a greater relatedness to inanimate objects. However, as Harry Stack Sullivan[3] pointed out in one of his early papers, the lack of affect observed in schizophrenics is often only apparent; and more careful observation elicits the hostility and anxiety so well masked by the apparent indifference. Even in the cases described by Kanner[2] and Mahler,[4a] apparent indifference seems more like an operation of selective inattention to persons, in contrast to the interest and attention directed toward certain toys and pet objects.

In this paper, the writers use the term "autistic" to connote the inadequate, interpersonal relatedness of the child, as demonstrated chiefly by his lack of successful, meaningful, verbal communication, in spite of demonstrated linguistic and physiological capacity. All three children have shown this capacity, and in rare moments, they transcended their illness to make true verbal communications. However, the vocalizations, gestures, and words were private and were failures in true communicative power for the most part, except insofar as a child's symbolic behavior was at times shared exclusively with his mother.

Judging from the literature, it is apparent that there is marked disagreement among investigators on the relationship of blindness to the emotional disturbance of a child. Currently, most workers seem to agree that retrolental fibroplasia is not a generalized neurologic condition and that there is no associated brain damage, although the frequent occurrence of developmental retardation in children born with retrolental fibroplasia had led people to make the opposite assumption. Norris et al.[5] conclude from their studies that blindness per se is not a determining factor in the child's retarded development. They intimate that it is chiefly the disturbances in the child's milieu, such as attitudes of family and school, that account for any abnormal psychological development. Hallenbeck[6] concludes, judging by the demonstrated improvement of disturbed blind children treated psychotherapeutically, that there is no basis for the belief that severe retardation of development is caused directly by blindness itself or by some

organic brain lesion associated with retrolental fibroplasia. However, she believes that there is a positive correlation between the child's development and the amount of vision he has. Also, she feels that there is a proportionate relation between the amount of visual loss suffered and the degree of closeness required in a positive relationship to achieve normal development.

Burlingham,[7] on the other hand, concludes from her analytic study of two cases that blindness per se diminishes the child's capacity for reality-testing and leads to a more active fantasy life. Deutsch,[8] in a series of psychologic experiments, also notes that blind children evidence a striking readiness to give up reality and escape into fantasy. Boutonier and Henri[9] likewise stress the damaging effect of blindness per se. They find that this handicap "crystallizes the blind person's emotions around his auditory and tactile perceptions and deepens his feelings of insecurity because he is lacking in a gamut of sensations which would enable him to secure rapid and definite information about his environment."

It is not within the scope of this study to solve the question of whether it is chiefly the primary handicap of blindness itself or factors secondary to it that determine the child's disturbed or retarded development. Furthermore, the child himself brings with him certain characteristics from birth which have their determinants in his heredity and embryology. To what extent these "primary" constitutional factors (such as "temperament" or the "maturational lags" postulated by Bender and Freedman[10]) play a role in the emotional illness of these children, remains conjectural and outside the scope of the writers' observation. They have attempted, however, to observe the psychopathologic patterns in these children and their crucial relationships to their parents, and to arrive at a working hypothesis of the pathogenesis of these patterns.

Clinical Case Reports

Case 1

Presenting Problems. Aldo R. is a six-year old boy, blind from birth, with retrolental fibroplasia. He was referred to the Roosevelt Hospital Child Psychiatric Clinic by a psychologist, who had evaluated him for admission to a nursery school and found him very disturbed emotionally, although "probably of average intellectual capability." Aldo's mother

felt that the chief problem was his poor speech. She insisted that he could speak but was simply rebellious and stubborn. He had shown serious developmental lags and regressions in his eating habits, toilet behavior and walking ability, and although she did not mention it, it soon became evident that he was quite unrelated to other people.

When first seen in the clinic, Aldo was rather large for his age, with very pale complexion and unseeing eyes, sunk rather deep in their sockets. In most of the interviews, his behavior was unrelated to the therapist. His "play" consisted of throwing play objects to the floor. The sounds he uttered were unintelligible, but he would sing songs quite musically and with most of the lyrics. His postures were chiefly lying on the floor, and sitting in a chair or on the doctor's lap, with very flaccid muscle tone.

Developmental History. According to his mother, Aldo was born two and a half months prematurely and required an incubator. Although she suspected "very early" that there was something wrong with his vision, she did not take him to an ophthalmologist before he was six months old. Aside from a few other ophthalmic consultations, she did not seek any other professional help for the child until she brought him to nursery school when he was almost six.

Aldo was bottle-fed and had no particular feeding problem, except that he had not yet been weaned from the bottle when he first came to the clinic. He was bowel-trained and bladder-trained at three, but until recently someone had always taken him to the toilet and helped him with his clothes. Walking began at one year and two months, but stopped for some weeks, as did his talking, after he fell and incurred minor injuries. (These may be considered as regressions following rather slight traumata.)

When Aldo was a year old, he began imitating words, and repeated whole songs between the ages of two and three. At three and a half, he began forming whole sentences and making his wants known. Soon thereafter, his parents separated because of marital discord, and Aldo's speech regressed.

He then made his wants known by gestures to which his mother would respond immediately, although she admitted that she would slap him in her anxiety whenever he began to shout and shriek. (Aldo still has a gesture of covering his mouth when he whispers certain neologisms, and it can be speculated that this suppressive behavior on his mother's part may have also interfered with his speech development. There is some belief among those who work with blind children that they have a greater need to shout out than sighted children.) More recently, there had been an open struggle about Aldo's refusal to talk. At times his mother got so angry that she refused to respond to the gestures which had become

a crucial part of his communication. After her husband left home, she and Aldo shared the same bed, went to bed at the same time, and sang lullabies to each other. Aldo rarely played with other children and had few contacts outside of his immediate family.

Therapy. The quality of Aldo's behavior at the clinic did not change markedly, especially during the early part of his treatment. His greatest expressiveness was in his gross motor behavior, and he became more clinging as therapy proceeded. He continued to slap his head and occasionally developed what seemed to be a crisis, in which he seemed extremely unhappy and fearful, alternately clinging, pushing away, kicking and crying. His ambivalent, alternating behavior had its counterpart in his mother's response to these crises. On one such occasion, observed by the therapist, the mother brought Aldo's face to her bosom and soothed him verbally, but as he began to cling to her and kiss her neck, she pushed him away with disgust. He began to cry again, and the cycle repeated itself several times in 15 minutes with its alternating clinging and rejecting pattern.

Aldo was his most expressive and communicative to the therapist, in his dancing to music. He also found pleasure in playing with water and in touching a variety of materials that were presented to him, although he never attempted to shape or use the materials in any organized or goal-directed way. However, there has been very limited progress in his verbal communication to the therapist; and, only in the last few months, after one and a half years of therapy, has he occasionally made such communicative statements as, "No, don't want to go into the room," and, "Stop it."

One phase of the therapeutic program for Aldo was to find a place for him in a supervised nursery school. This proved most difficult since no institutions were found in the Metropolitan New York area with programs for emotionally disturbed blind children. A compromise stiuation was found at a school for the blind, which he has been attending up to the present time.

Aldo has demonstrated the most striking of the changes he has shown, since he began attending this nursery school, during his second year of therapy. His tantrums have greatly diminished, and he is responsive to the consistent firmness and intuitive understanding of his teacher. He now takes care of more of his personal routines such as washing and eating. In his first year of therapy, he was weaned from the bottle, at which time he first started using a knife and fork with some success. Although the teacher reports a strong temptation on her part to respond to his private signs, she has held back until Aldo asks verbally for what he wants. Regular conferences of clinic and nursery school personnel

have been found most useful in co-ordinating activities and goals, as well as in dealing with difficulties that arise in working with such a child and mother.

Some significant changes in the mother's resistive attitude toward Aldo's therapy have been accomplished by her weekly visits to the social worker, with whose support Mrs. R. has grown more able to relinquish her reliance upon her son for her satisfaction and sense of security.

The goal of the therapy at the clinic was to introduce Aldo to a new kind of relationship, through the therapist, and to experiences in touch, smell, sound and movement, by which he could make contact with the outside world more directly. It was hoped that this would decrease his dependence upon the "seeing eyes" of his mother, and lessen the need to retreat into his isolated fantasy world with its private symbols, gestures, mannerisms and neologisms. Although improvement has proceeded slowly, there have been definite encouraging trends which are expected to be uneven and halting in so damaged a child.

Case 2

Presenting Problems. Robert J. is a six-year old, an only child, blind from birth, with retrolental fibroplasia. He was referred to the clinic by the Lighthouse for his severe emotional problem; there was also some question about mental deficiency. Robert's father believed that the boy's chief problem was a psychological one, which he felt was concealing an unusual talent and intelligence. He spoke with pride about how well Robert could recite poetry and sing radio commercials. The mother went along with this belief, complaining mainly of the child's stubbornness.

When Robert started coming to the clinic, he was small, slender, pale, with deep, dark eye sockets, fat baby cheeks and thick red lips. The mother very clearly described his passive relationship to her ("He didn't even hold his bottle"), his lonely attachment to his pillow, and his general apathy ("He never cared for toys"). She also revealed her preoccupation with appearances in the somewhat laconic remark, "He is the most wonderful child to travel with."

Developmental History. Robert was apparently a full-term baby, but he weighed only four pounds at birth and required an incubator. His blindness was discovered during a routine physical examination and was diagnosed as retrolental fibroplasia. (No help was sought until he was three years old, when his mother entered him in the Lighthouse Nursery School.)

As a baby, he was breast-fed for the first three or four weeks. He sat up at six months and walked at two years. His walking was always unsteady and he displayed a tendency to hold on to something or someone

while walking. He began to talk at nine months and had a vocabulary of 19 words in his twelfth month, when he suddenly stopped talking, after developing glaucoma (regression due to trauma). He resumed talking at 18 months, when he was taught by his father to count up to 20, recite poetry, and sing radio commercials. He started to combine words when he was three years old but has rarely spoken in complete sentences or displayed any conversational speech since that time.

There was a severe feeding problem with Robert from the very beginning. Until recently he has taken only pureed foods and has never chewed any of his food. He usually had to be forced to eat, with gavage a frequent necessity. He has always had violent tantrums, and is extremely impatient, often given to screaming and banging his head. He had never been completely toilet-trained.

The nursery school, which he began attending when he was three, reported he was characteristically limp and that he clung fearfully to the nearest adult. At that time, Mrs. J. was hostile to any suggestion regarding Robert's care, and was extremely defensive about his severe retardation. Two years later, he was referred to the Child Psychiatric Clinic at Roosevelt Hospital for treatment.

Therapy. At the first interview, it was apparent that the mother was trying to cover up her hostility with polite indifference. Robert responded to her demands for performance with a kind of histrionic defiance that had a rather hollow, mechanical quality. He also expressed a diffuse, helpless, fearful excitement.

The next interview was with Robert alone and took place several months later, after summer vacation. At the beginning of the hour, he said, "I am a sick boy because I do not love my mother." He did not utter one more word for a long time, except for occasionally echoing some question or remark. He spent the rest of the session in rocking back and forth. In the next few interviews, he came into the doctor's office without reluctance, although with seeming indifference. Sometimes the doctor would make noises and they would imitate each other. He liked to cuddle in the doctor's lap and rock back and forth there, sucking his thumb and making noises. Soon thereafter, the mother reported improvement, but was unable to bring Robert to the clinic for a full month because of alleged transportation problems. This gave an opportunity to explore the mother's apparent need for maintaining the boy's infantile state.

A year after starting treatment at the clinic, Robert showed slight improvement in the direction of reaching out for his mother and certain toys. However, the parents, now facing the child's problems more realistically, recognized the need for residential treatment. Since there were no local facilities available, he was referred to the nearest residential

treatment center, several hundred miles away. The diagnosis of autism was confirmed there, and a strong recommendation was made that Robert's parents continue to receive help in resolving their own tensions and conflicts about him.

By this writing, the mother has progressed from the frightened, overprotective, defensive, hostile woman she has been, to a much more assertive and warmer person, involved in more realistic planning for the child's future. The father has also given up his grandiose ideals for Robert and has openly expressed the terrible disappointment and hurt he experienced over the child's blindness and poor development. Robert at last became completely toilet-trained at the center. To a very limited extent he was able to participate in play with several of the other children, though with only one at a time.

Case 3

Presenting Problems. Dorothy R. is a seven-year old, Spanish-American girl whose blindness from early infancy, due to bilateral central chorioretinitis, was discovered when she was two months old. She was not so autistic or retarded as Aldo or Robert. She was referred to the clinic by her nursery school, which reported that Dorothy made very little sense in her conversation, constantly repeating things she heard, and that she could not relate to the situation at hand. Dorothy's mother felt that the child's chief problem was her stubbornness.

When mother and child first came to the clinic, they were both pale, very obese, and extremely tense. The child was very confused and distracted; the mother was hostile and anxious, alternating frequently between outbursts of vindictive scorn and anxious solicitude.

Developmental History. Since earliest infancy, Dorothy was always a fearful child, with great difficulty in sleeping. She was a "good eater," however, and soon became very obese. She was slow to develop in all respects. She walked at about two years, talked at 14 months, was bowel-trained at two and a half years, but has been frequently enuretic until now, at seven years of age. (The "good eater" aspect of her personality was soon recognized at the clinic to be a frightened submission to her mother's compulsive, angry and forceful feedings.)

At the age of five, Dorothy underwent a tonsillectomy and was separated from her parents for a night. Following this experience, she became much more fearful, suffered nightmares frequently, asked for reassurance constantly, and screamed at being left alone. The New York Association for the Blind, where she had been seen just before entering nursery school at three, reported to the clinic: "Dorothy was extremely fearful of strangers. It was apparent that her parents anticipated her

every desire, with the result that she was badly spoiled and had no opportunity for development. The mother was reluctant to have her out of her sight; and only on rare occasions, when relatives came to visit with their children, was Dorothy allowed to play with anyone. When arrangements were made for Dorothy to begin attending nursery school, the mother gave the impression that she did not wish to be separated from her child. The consulting physician expressed the opinion that the parents were striving for too much success for the child, in view of her visual impairment, but that, at the same time, she was being overprotected in matters which she could easily handle for herself."

Therapy. In contrast to the preceding two cases of severely autistic, totally blind children, Dorothy quickly related to the doctor at the clinic on a verbal level. At first, she kept asking about going to school and asking where she was, where her mother was, and where the doctor was. She asked this kind of question repeatedly during many sessions. She also denied any visual trouble, insisting that she could see. During this time, the mother was extremely defensive, and was apologetic for every mistake the child made.

Dorothy refused to play with toys, saying that "only babies play with toys." During one of her later visits, when she came with her father, she pretended that the doctor was her baby sister and appeared confused as to what was play and what was real. She yelled at the doctor and at her father and acted, as her father said, "just like her mother." At times, she spent most of the hour pretending to feed the doctor in a very anxious and angrily forceful, bullying way. This kind of play, which continued for about six months, was always combined with fearful demands for reassurance that her parents were still waiting for her.

Later on in her sessions at the clinic, she began to play with finger paints. She identified all the colors easily, and enjoyed smearing them and mixing them until they were all brown and black. During this time, she talked about her younger sister and her sister's toilet activities, expressing some guarded resentment and envy of her. When the doctor asked her how she was deprived by her sister, she became very upset and said that she hated the doctor and the hospital. Her father, who was waiting outside, was called in; he reassured her that he loved her, and she gradually calmed down and talked more coherently.

After a year and some months of treatment, she was a smiling, bouncing girl, having lost her obesity. She spoke clearly and coherently, with little anxiety about being alone with the doctor, though she still seemed very anxious about separation from her mother. She initiated play spontaneously and seldom asked for help in the play situation. During the following year, she spent much of her play in keeping things clean and

tidy, and moving furniture around. She washed the floors and the walls with much verbal expression of how disgusting and stinking they had been and how nice she had made them.

During the second year of Dorothy's treatment, the mother had been growing increasingly anxious and disturbed, and at this time she began receiving treatment in the out-patient psychiatry clinic. She began to clarify the problems she had in her relationships to her own parents, and she improved her relationship with her husband.

Clinical Summary

On the basis of these case histories, it is interesting to speculate about how different these children might have been if they had not suffered from blindness. The question comes up of how important the blindness was, as compared to other defects, in triggering the complicated relationships that developed within the family. There is also the question whether, without any defect, these children might not have developed similar pictures, since the three families had much in common.

In all three cases, the child was the first-born; and, except for Dorothy after the age of three, they were only children. All three mothers were extremely anxious, with intensely contradictory attitudes toward their children. None sought help on her own initiative, or recognized any serious mental condition in her child, although in all three cases, it was very obvious that the child was isolated, severely retarded, and very disturbed. Moreover, each was grandiose in her almost dream-like expectations of the child's eventual performance, though very impatient with his everyday difficulties. The mothers interfered and did many things for the children, thus preventing them from learning through their own efforts. They were all very lonely, frightened women who found overt comfort in the clinging, infantile behavior of their children, which they sought—at the same time that they rejected it, out of their guilty anxiety and frustrated ambition. Unhappy with their husbands, having few, if any, friends, their time was taken up by their sick involvement with the equally lonely, even more frightened, and much more helpless children.

The fathers in these families were also less than adequate. Dorothy's father was confused and relatively detached. Robert's father tyrannized his wife, and treated his child with overwhelming permissiveness or with demands for evidence of genius, having

blinded himself to the reality of the child's condition. Aldo's father openly resented the child and soon broke up his marriage and abandoned it. In no case, was the father a source of strength, stability or resourcefulness.

The children in all three cases demonstrated their infantile state of development by their severe oral difficulties and other problems. The more retarded of the children, Robert and Aldo, took their nourishment from a baby bottle until they were five and six years, respectively. Dorothy over-ate during a continuous struggle with her mother's compulsive feeding. Two of these children never ate on their own initiative, exercised any appetitive selection of food, or co-operated in the feeding relationship in any way. As seen, especially in Aldo and Robert, there was an extreme problem in the development of communicative speech. None of the three enjoyed the exercise of language beyond the babbling stage; they had little incentive and were not taken seriously as individuals in their own right. This was less true for Dorothy, whose father was, in spite of his detachment, a more positive and stabilizing force than the other parents.

All three children had severe tantrums and expressed considerable indirect hostility toward their mothers, which, of course, the latter tolerated with great difficulty. The women alternated, sometimes in a single moment, from pretended indifference to vindictive retaliation. The hostility of the children on the one side, and their frightened clinging on the other, were the two horns of their dilemma. Both aspects of their behavior expressed in part a healthy urge toward developing more fully, with greater assertion and more genuine feelings and, at the same time, demonstrated the very factors that interfered most with their healthy emotional development.

Much of the therapy in such cases can be worked out through direct personal experience between the child and the psychiatrist in intensive psychotherapy, but change in the parents is of greatest importance. This change may be accomplished—through the help of the psychiatric social worker—in a joint effort with doctor, psychologist, teachers and social workers. The general goal of this teamwork is to help the parents develop insight into their separate personality difficulties and into their relationships with each other. As a better-integrated unit, the family can be more inti-

mate and more effective in coping with the serious emotional illness of the child. In the intensive psychotherapeutic experience between the doctor and these children, attention was focused on various ways of establishing and maintaining communication and empathic rapport. Because of the children's blindness and their lack of verbal facility, emphasis was placed on rocking and dancing movements, singing songs together, touching each other, playing records, imitating noises and movements, and so on.

This program of working together with the social worker to help both parents, and working with the child in psychotherapy, was combined with regular consultations between the clinic team and the teachers of the nursery schools for the blind, which the children attended. In this way, a more fulfilling environment could be established, where the child could begin to explore his capacities for new experiences with other children and adults. Where institutional care was found necessary, the clinic team was able to work out a plan of helping the parents make the necessary adjustments.

Discussion

There were two striking forms of disturbance found in these three blind children—developmental retardation and autistic behavior. Lags and regressions were observed in many areas of their development, but the most notable defect, and perhaps the most damaging to the growth of the rest of the personality, was that of inadequate verbal communication. In association with this, the children developed relatively private systems of symbols, which were reflected in their gestures, mannerisms, vocalisms, and neologisms. In many instances of this kind, certain symbols which make no sense to the outside world are understood by the child's mother, who has become a symbiotic part of the child's "private" world. To be sure, a measure of this "understanding" on the mother's part appears to be a rationalizing of the disappointing and unacceptable private productions of the child.

It has been found that the parents of these children, especially the mothers, experience feelings of extreme guilt and anxiety, with very limited satisfactions and security. They show their feelings of guilt in relation to the child's blindness, as well as to his emotional and developmental disturbances. To help undo and atone for these feelings, a mother becomes very preoccupied with being

the ideal "good mother," which means to her "giving mother." However, such a mother, because of her own feelings of impoverishment and need, finds it difficult to feel adequate as a giver unless she conceives of her child as quite helpless and dependent, even more needy than she, and too damaged to do anything without her. This under-evaluation of her child by the mother undermines his self-confidence and contributes greatly to his feelings of inadequacy and helplessness, thus reinforcing his dependent clinging to her. Immediate responses to the child's minimum cues may so decrease the tensions of his needs at those points, that more articulate and forceful expression of those needs becomes, for the most part, unnecessary. The writers are going on the assumption here, of course, that the tension of needs is a powerful motivating force for verbal communication, and possibly for the learning of language in general. If this is so, continued response on the part of the significant adult to pre-verbal cues, such as gestures, can actually undermine the development and use of verbal communication. Moreover, since in the case of the particular children under discussion, their mothers were almost always in their presence, there was little need or opportunity for them to develop "public" or conventional symbols, which would be subject to validation by the response of the world outside the relatively private symbiotic worlds that they shared with their mothers. Hence, there was little opportunity for them to learn by trial and error or by consensual validation.

The vicious circle thus established is largely maintained through the mother's sharing in the child's autistic productions, wherein a private language is developed between them. To the extent that communication between the child and his mother is shared and yet is exclusive of everyone else, the child's autism might well be called "shared autism." There is a large overlap in the meanings of an exclusive "mother-child symbiosis" and a child's "shared autism." The former focuses on the bonds between the mother and the child, whereas the latter focuses on the isolation of the child from the world that is outside his mother. In the three children that the writers treated, there was much autistic behavior which was "unshared" with the mother or anyone else.

The mother's "premature" response to some of the autistic child's needs also seems to relate to her wish to avoid the increased

anxiety and guilt which would result if she allowed the child's tensions to build up. Hence, Aldo could grimace in a certain manner or hold his hand to his mouth, and his mother would immediately appear with a bottle of milk. Although this might be considered a sensitive and empathic response by a mother to an infant, it is a sign of severe psychological disturbance in the mother when she responds in such fashion to a six-year old child. One might ask if the handicapped child is not really more dependent upon his parents than a normal child and thus more in need of attention, protection, and sensitive responsiveness. The answer is probably in the affirmative for many cases; but such a situation can be kept healthy only to the extent that the parental giving is primarily for the child's needs and growth toward independence, and is not a crucial factor for the maintenance of parental self-esteem. There is also evidence that the mother in such cases suppresses certain of the child's needs or shows selective inattention to them, in an attempt to escape the anxiety provoked in her by his tensions. As for the mothers involved in this study, their capacity for any sustained affection was markedly limited.

This leads to a consideration of the pathologic symbiosis that exists between mother and child in such a relationship. The basis of their symbiosis is the maintenance of an exclusive mutuality of needs and the promise of fulfillment of these needs. Each "partner" feels that either his survival or his security, or both, would be in jeopardy without his dependence upon the other. Blindness and other handicaps in children afford ready-made foci around which such symbiotic systems can develop, because there are in reality areas of obvious helplessness in the children. Such a situation may be unconsciously exploited in the conscious attempt to be a "good mother." In such a relationship, the mother becomes the "seeing eyes" of the child, instead of encouraging him to experience the world more directly through the part of him that is healthy and intact. Moreover, since the maintenance of the symbiosis depends on a closed system of the "partners," any outside influence which tends to increase the child's independent growth is regarded as a threat. This is probably one factor in Hallenbeck's finding[6] of a correlation between the severity of the child's psychopathology and the delay on his mother's part in seeking professional help. One might infer a similar correla-

tion between the delay in seeking professional consultation and the degree of parental disturbance. The present case material strongly supports these inferences.

One might ask why such a state of symbiosis does not work out to the mutual satisfaction of both partners. In the early infant-mother relationship, as well as in many other realms of nature, there is successful symbiosis, with mutual benefit and satisfaction of needs. The newly-born infant achieves fulfillment of his needs and affords his mother the opportunity for the expression of tenderness and of her need to do mothering. Because of the human infant's singular state of helplessness at birth, this extreme, early dependency is quite appropriate and, in fact, necessary for survival. However, to continue the early symbiotic relationship much beyond infancy, is to ignore and frustrate the child's growing need for investigation, communication, and contact with the outer world. In his extreme dependency upon his mother, there is no preparation for the reality of the outside "public" world, that is, society. The child is kept isolated from the culture he lives in as long as his mother fails in her role as intermediate "culture-carrier." He is left with a poorly-developed or damaged ego structure, whose shape has largely been molded by the needs of the mothering adult.

This frustration of the child's needs and their subjugation to the needs of the mother lead to his negative and hostile reaction toward her. In fact, in Aldo's case, one sees a strong ambivalence in his feeling toward his mother. In his rage at her, in his pushing her away, and in his verbalization, "Leave me alone, I need some air," there seems to be a part of him that seeks to grow and escape what he feels to be stifling and threatening. In alternately clinging and melting in his mother's arms, and then pushing her away and withdrawing, he expresses conflict between his pathologic need for symbiotic closeness with her and his fear of being smothered by her.*

The mother's similar oscillation of attitudes from closeness to distance toward her child, has already been described in all three of the writers' cases. The rejecting phase of the mother's be-

*Since this paper was first written, Mahler and Gosliner (Ref. 4b) have published an article expressing very similar ideas. They say, "... the boy seeks to attain an equilibrium between the need of his weakened ego to obtain constant supplies from her and the threat of being engulfed and losing his self-identity to her."

havior seems to be related to her anger and disappointment in the child. Originally, she regards the child as a potential source of her own fulfillment, but he eventually fails her in this. He is not the "genius" she hoped he would be; in fact, he is a severely disturbing problem and an obstacle to the expression of some of her own adult needs. She is also angry with him because she regards him as the source of her guilty feelings. Her behavior demonstrates two opposing attitudes: a beckoning, seductive, "close" phase which is invariably followed by a rejecting, angry phase. These two kinds of behavior constitute the continual contradictory oscillation which the child experiences from her. This cyclical pattern prevents the establishment of a healthy mother-child equilibrium, as it continually shatters the frame of reference upon which the child's ego must grow, and, therefore, leads to uncertainty, panic and rage. These experiences, if severe and of long duration, may force the child to withdraw in apathy and seclusion, defenses similar to those observed in the schizophrenic. One can, therefore, postulate that much of the autistic behavior observed in the three cases was a defense against this kind of shattering, contradictory, oscillating cycle of experience. Sullivan[ab] has described the protective nature of the infantile dynamisms of apathy and somnolent detachment, in dealing with the excessive tension of frustrated needs and the anxiety of interpersonal insecurity. Both of these dynamisms are probably similar to the defensive withdrawal that is seen in autism.

Bender[11] also contrasts, in schizophrenic children, two gross motor patterns of behavior which seem similar in several respects to some behavior in the present cases. She describes a centripetal whirling, clinging, and melting behavior which can alternate with a tangential darting elusiveness. She further describes this elusiveness as an attempt at "escape from the organized center of gravity," and suggests that it may represent an attempt to escape from dependency on the mother. The clinging and melting behavior that she mentions appears very similar to that observed in the symbiotic relatedness of the cases presented here. Mahler[48] states that the aim of such behavior is "restoration and perpetuation of the delusional omnipotence phase of the mother-infant fusion of earliest times—a period at which the mother was an ever-ready extension of the self, at the service and

command of 'His Majesty, the Baby.'" However, Mahler clearly delineates two types of infantile psychoses, the autistic and the symbiotic. Although she also describes the defensive operation of autism, she gives this type of behavior a specific developmental root when she refers to it as a distinct psychosis. She states that autistic children have never experienced the mother as the love-object, thus implying that they could not have any symbiotic strivings. In the writers' cases, certainly, the defensive nature of autism and its co-existence with symbiotic relatedness was quite striking. Mahler agrees that such mixtures are found in more long-standing illnesses. However, the writers would like to present the thought that the pure autistic psychosis Mahler describes is perhaps a severe and encrusted defense against unsatisfactory relatedness, and that this defense masquerades as the total psychosis, especially because we do not yet know how to reach such children. Although the writers can imagine the possibility of a primary constitutional defect in the child's ability to relate to the mothering one, they feel that it may be more potentially therapeutic, and perhaps more scientific in that it would be operating on fewer assumptions, to assume the defensive nature of autism in each individual case until there is proof otherwise.

Conclusion and Summary

A brief review has been presented of the important literature on autism and the relationships among blindness, emotional illness and developmental retardation. Three cases of emotionally disturbed blind children have been presented.

All three blind children in this study exhibited severe developmental retardation. They all had similar psychopathology, and they had common trends in their relationships with their parents. Some of the therapeutic problems, goals and techniques involved in treating such children were discussed.

It was observed that the relationship between the child and doctor was so restricted by the autistic disorder that communication was often carried on at a nonverbal level by such means as simple rhythmic movements and noises. Psychological testing, likewise, required a different approach and a special background of experience. The social worker was a very vital member of the clinic team. She maintained close and frequent contact with the

parents, and co-ordinated the treatment program with the nursery school.

Four phases of the therapeutic program have been described: 1. The individual work of the psychiatrist with the child. 2. Consultations with parents by the psychiatrist and the psychiatric social worker. 3. Placement of the child in daytime school programs, with regular consultations with the teachers. 4. Placement in institutions for disturbed blind children for those who could not be treated on a once-a-week clinic basis.

One of the characteristics of the disturbed child-parent relationship that was observed was a "shared autism," in which a private system of communication was developed between child and mother. This system, consisting of certain gestures, vocalizations and verbalizations, impeded the development of normal verbal communication and relatedness. The failure inherent in this pathologic, symbiotic relationship led to a pattern of alternating cyclical ambivalent behavior. This cycle of clinging closeness and hostile rejection provided no stable frame of reference upon which the child's ego could properly develop. Hence, any healthy equilibrium was impossible, and the child was forced to develop the constrictions and autistic defenses described. The relative helplessness of normal, healthy children can probably evoke in some disturbed parents patterns of relatedness similar to, although perhaps more subtle, than the ones described in the parents of the three blind children. Therefore, some of the patterns described in this paper may be useful in increasing the understanding of parents of schizophrenic children. Even in cases where a primary constitutional ego defect might be postulated, the alleged constitutional defect may act as the trigger for the vicious circle of anxious parental over-responsiveness, just as the handicap of blindness does. The greater the real helplessness of the infant or child, the greater the parent's feeling of guilt is likely to be, as well as the greater the temptation and pressure on him to overcompensate for his offspring's difficulties, whatever the psychologic reasons for them may be.

It is urgent that the emotional disturbances of such handicapped children be detected early. This is important since there is the danger of explaining, all too easily, the psychological deviations on the basis of a child's handicap, rather than exploring the severe

child-parent disturbances which have become organized around the handicap. Further education of the physicians, teachers and parents of these children would help foster mental health, as well as aid in the early diagnosis and appropriate referral of these children and their families for much-needed psychiatric consultation.

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THE USE OF UNIDIRECTIONAL CURRENT IN THE TREATMENT OF MENTAL DISORDERS*

A Preliminary Report of Various Procedures, Including the Succinylcholine Chloride Modification of the Low Amperage Unidirectional Convulsion

BY JAMES E. RAPPA, M.D., AND HERMAN TANOWITZ, M.D.

A Reiter Machine, Model CW47C, utilizing a spiked, unidirectional electric current, was employed for therapy at Brooklyn (N.Y.) State Hospital for the first time on February 4, 1954 and was used continually thereafter on all patients receiving treatment on a ward, which was specially chosen for this type of treatment.

The low amperage, unidirectional current was found to produce a different muscular response than the convulsions effectuated by the use of alternating current. The tonic-clonic phase has been modified in that the usual initial flexion thrust is largely suppressed. The clonic phase is reduced considerably in intensity and amplitude. During the convulsion the joints of the upper extremities usually remain flexed. Occasionally either unilaterial or bilateral extension at the elbow is noticed. The lower extremities are extended at all times during both phases of the convulsion.

Blood pressure is rarely elevated and, in some patients, is even reduced. Pulse abnormalities are not so frequently encountered as with alternating current shock. On occasion, it is possible to initiate respiratory movements before the end of the therapeutic convulsion. This is of great importance in counteracting the general hypoxia caused by the apnea which accompanies the convulsive responses. Amelioration of the respiratory and cardiovascular complications and of the mental confusion usually resulting from the postshock effects of standard electric convulsive therapy has made it possible to treat a greater number of mentally disturbed patients than could otherwise be handled.

Preliminary evaluation of the results obtained has shown no differences in the rates of recovery of patients treated with the two types of currents. There is no substitute method for effective treatment where the regular convulsive grand mal response is needed. However, the Reiter machine has made possible a

*From Brooklyn State Hospital, Brooklyn, N.Y.

variety of other approaches which appear to have symptomatic efficacy in many of the psychoses.

Techniques Used at Brooklyn

Notes on the various electric therapy techniques used at Brooklyn State Hospital follow:

1. *Production of a Standard Grand Mal Reaction by Alternating or Unidirectional Current*
2. *Unilateral Convulsive Treatment*

Unilateral convulsive treatment may be used on patients with cerebral pathology and with existing paralysis of the extremities. By proper application of button electrodes, a convulsive response can be obtained in the unaffected heterolateral side.

Case 1

The unilateral convulsive method is indicated in patients who have already had strokes. An example of the response to unilateral techniques is the case of a patient who was admitted on January 7, 1955 at the age of 57. His history revealed little schooling and the fact that he had lived a rather precarious life at the time of the Russian Revolution. His adjustment at all levels had been described as satisfactory until the onset of the illness that led to hospitalization. He was described as a rather strict and hard-working individual.

Sometime in 1953 he lost his job as a presser and, in the process of making the rounds of unions, taking odd jobs lasting for a day or two, he became increasingly nervous and upset. On October 4, 1954, he was admitted to Fitzsimmons Army Hospital because of tremors of the left extremities. The diagnosis was paralysis agitans. While at this hospital he became extremely agitated, hallucinatory and disoriented.

Approximately five months before his Brooklyn admission he began to express ideas of reference concerning Communism, and that people in the street were looking at him and following him. Just before his admission, he developed confusion, disorientation, marked paranoid ideas, agitation and suicidal thoughts. He was diagnosed, psychosis with cerebral arteriosclerosis associated with Parkinson's syndrome.

On March 30, 1955, a course of ECT, using the unilateral Reiter machine technique was administered. There were three treatments over about 10 days. It was felt advisable to discontinue treatment because of the organic pathology of the brain and general debility. However, the patient seemed to improve, so that approximately four months after his last treatment he was noted as being neat, pleasant and co-operative. He no longer

complained about "Communists" and was free of delusions. There remained one aspect of his psychosis, mainly an hallucination, in which a voice would tell him to go home to his children. Nevertheless, he was permitted to go home on weekends for visits where his adjustment was good and without untoward incident.

When last examined neurologically, he showed rhythmical tremors of the left upper and lower extremities, miotic pupils reacting neither to light nor accommodation, and hyperactive deep tendon reflexes. The neurological diagnosis was arteriosclerotic Parkinson's syndrome.

3. *Spread Convulsive Treatment*

Beginning with the unilateral technique, the current is raised, stimulating the ipsilateral side, thus slowly and gently provoking a generalized convulsion. The technique can be used in the presence of cerebral and cardiovascular pathology or in marked debilitation of the patient.

4. *Nonconvulsive Techniques*

Nonconvulsive techniques are apparently effective in producing symptomatic relief in anxiety tension states and hyperactivity, and may result in greater relaxation and mild euphoria when used in agitated depressions. A temporary calming effect has been noticed in some of the patients receiving nonconvulsive electric stimulation. Of special interest, is the ameliorating effect in hypochondriasis. It was especially valuable in a case of involutional depression associated with agitation, severe hypochondriasis, and insomnia. In that case—because of cardiovascular contraindications—nonconvulsive therapy was administered initially and later followed with regular convulsive treatment.

Nonconvulsive abreactive techniques appear to increase alertness and awareness in some of the chronically ill patients refractory to convulsive therapy.

Case 2

Nonconvulsive techniques have proved helpful in the application and continuation of maintenance therapy for extended periods. An example is afforded by a 58-year-old male patient. An only child, he was raised by overprotective parents and always considered to be introverted and tense, but was a good student and was graduated from high school without difficulties. His relationship with the opposite sex was poor. He was drafted into the United States Army during the first World War. After discharge from the army, his tension and anxiety became

diffuse and free-floating, making life unbearable. At the age of 35 he married, at the urging and prodding of his parents. The marriage was unhappy and tension-creating; three months after it, he developed seizures simulating epilepsy.

In 1931, he suffered severe money losses as a result of which he suddenly experienced a recurrence of his seizures. He became agitated, jumped up and down and engaged in bizarre grimacing. He was admitted to the Psychiatric Institute February 6, 1931, and remained there until March 5, 1931, when he was discharged against psychiatric advice. Tension and anxiety symptoms remained, varying in intensity and occasionally resulting in hospitalizations. On two occasions he received electric convulsive therapy. Early in his history he developed a severe mucous colitis, and became a constant visitor to physicians and clinics, seeking alleviation of this condition. He began to crave large quantities of barbiturates and soon developed barbiturate addiction.

This patient was admitted to Brooklyn State Hospital on October 13, 1953 with an exacerbation of symptoms. He received various therapies including electric convulsive therapy, without lasting relief. Following the termination of the ECT, he complained of feeling miserable and tense, anxious and unable to enjoy anything. On November 22, 1954, unidirectional nonconvulsive treatment was started, and 14 additional treatments were given, spaced three times weekly, thereafter. Each treatment lasted until the patient was able to ventilate his ideas coherently, with the electric stimulation being maintained for an average of seven minutes. During the intervals between treatments, he acted with marked joviality and was seen to function appropriately. He said he no longer felt tense and voluntarily offered to help the ward personnel. Increased accessibility enabled the psychiatrist to conduct psychotherapeutic sessions with greater economy of effort. At no time, was there evidence of organic confusion, which almost inevitably accompanies the convulsive therapies. A marked reduction in tension and anxiety was immediately noticeable and lasted until about a month after completion of the non-convulsive treatment. At this time feelings of inner turmoil, tension and anxiety began to reappear, and the patient was then started on thorazine therapy.

5. *Combined Nonconvulsive and Convulsive Techniques*

The effects obtained by combining nonconvulsive and convulsive techniques reflect, in most cases, the changes produced by the individual therapies. The rotation used is entirely dependent upon the indications of the mental and physical examinations.

Case 3

Case 3 is representative of the difficulties surmounted by successful

application of combined nonconvulsive and convulsive techniques leading to the restoration of reality functioning.

This patient, a 26-year-old white man, had been severely beaten before his hospitalization. He drank excessively, as a result of which he usually became disturbed and truculent.

On December 30, 1953, he was assaulted, and suffered a multifissured comminuted fracture through the upper end of the left tibia. Additional fractures in good position were noted through the posteriolateral aspects of the eighth and ninth ribs. He was treated at Kings County Hospital initially, but later had to be transferred to Brooklyn State Hospital on March 5, 1954 because of a developing paranoid condition.

At the state hospital, a diagnosis of schizophrenia, paranoid type, was made. His paranoid ideas increased; he became confused, fearful and thought that the other patients on the ward were plotting to kill him. In attempting to defend himself against imaginary attackers he began to assault various persons on the ward. He became violently overactive and continually more confused in his mentation. His productions were gibberish and completely incoherent. The use of intravenous barbiturates was limited, due to a demonstrated sensitivity to those drugs. It soon became apparent that unless the psychomotor activity was reduced, the patient would develop a state of severe exhaustion. Feeding him became a problem, and he was unable to retain feedings by a stomach tube. Periodic x-rays of the fractures showed all fragments to be in good position, but exhibiting retarded callus-formation. The patient's mental condition continued to worsen, making some form of electric convulsive therapy mandatory.

On March 23, 1954, a nonconvulsive treatment was administered with the Reiter machine for a duration of 9 min., 55 sec. The effects were dramatic. Toward the end of the nonconvulsive treatment the patient began to cry, with tears streaming down his face. He gave a completely rational account of his experiences. A great deal of material was obtained regarding the development of his fears and mental abnormalities. Near the end of the treatment, he appeared to have fully discarded his fear of the individuals surrounding him, and even pleaded with the physician to protect him against his real attackers. The opportunity was also utilized for feeding purposes, and he voluntarily ingested large quantities of food. On the following day, it was discernible that the patient was slightly more manageable and less apprehensive of his environment.

The man's favorable reaction to the nonconvulsive treatment was taken as an indication of future beneficial responses to the convulsive therapies. To avoid injury to the slowly healing fractures, it was decided to use

succinylcholine chloride* to soften the effects of the prescribed regular convulsions produced by the unidirectional current. (Thiopental sodium is frequently given in combination with the succinylcholine chloride.)

The first convulsive treatment was given on April 28, 1955. This therapy was continued three times weekly for a total of 26 convulsive treatments. The muscle-softening varied between slight and definite reduction in intensity, the responses having been judged in accordance with a schema worked out to evaluate the degree of muscle relaxation produced by succinylcholine chloride. The average dose of succinylcholine chloride was 48 mg., and the periods of apnea encountered varied from 10 to 20 seconds. ECT was discontinued on July 16, 1954 when it was felt that the mental and emotional improvement had become definitely stabilized. The patient left the hospital on January 3, 1955; his mental condition at the time was considered to be much improved.

6. *Countershock*

Countershock consists of the application of a low-intensity, nonconvulsive stimulation of ½ to 1½ ma. for 30 to 60 seconds following a regular convulsion. The electrodes are applied at the temporoparietal position.

The effects observed are: (a) Amelioration of respiratory and cardiovascular side effects. In cases of severe laryngospasm, this method resulted in a rapid alleviation of the stridor. (b) The appearance of greater relaxation and comfort postconvulsively in a number of patients, due to a reduction of anxiety and apprehension.

The countershock method is used routinely on all patients receiving convulsive therapy.

Procedures to Reduce Risks

To reduce further the risks involved, the following two techniques were utilized:

1. *Respiratory Stimulation*

Postconvulsive apnea is reduced to a minimum, as a result of stimulation of the respiratory center with the nonconvulsive Position 1 of the Reiter machine. Intravenous barbiturates can be given with greater safety because of the respiratory-stimulatory effects of the machine.

2. *Succinylcholine Chloride*

Succinylcholine chloride, a muscle-relaxant drug of short dura-

*Anectine. This preparation was obtained from Burroughs Wellcome & Co.

tion of action and rapid onset, is used in softening the muscular contractions produced with Position 3 of the Reiter machine.

The combination of unidirectional current and succinylcholine chloride appears superior to all previous techniques of a similar nature in the electric convulsive therapies. It has been found possible to decrease the amount of muscle-relaxant drugs needed to produce a softened convulsion in view of the altered muscle-responses to the low amperage, unidirectional current. Greater safety is thus attained in the use of the intravenous muscle-relaxant drugs. It must be emphasized that the Reiter machine has no direct effect on the respiratory distress resulting from the use of muscle-relaxant drugs. The foregoing combination was used with great success on a variety of patients not otherwise treatable. The method was especially effective in preventing severe complications in individuals with diverse cardiocirculatory disturbances.

Apparent Advantages of Unidirectional Apparatus

Apparent advantages in the use of the Reiter machine follow:

1. *Lesser Postconvulsive Difficulties*

There is a diminution in postconvulsive disorientation, memory disturbances and mental confusion. This is of great importance in the treatment of elderly patients who are suffering from marked arteriosclerotic changes of the cerebrum. In view of the lessened postshock confusion, a greater number of treatments can be employed, and the duration of each can be lengthened. It is also observed that patients receiving multiple treatments daily exhibit lessened organic mental confusion. In general, it can be stated that patients responding with decreased mental confusion will respond more favorably to concomitant psychotherapy. It appears that the nontherapeutic undesirable side effects of standard electric convulsive therapy methods are partially circumvented.

2. *Lessened Respiratory and Drug Problems*

Respiratory problems and barbiturate poisoning, with or without coma, can be favorably treated with the nonconvulsive Positions 1 and 2 of the Reiter machine. This capacity to counteract and reduce the deleterious effects of adjunctive drug therapy by means of the machine techniques has made possible the routine

use of barbiturates on all patients receiving electric convulsive therapy.

3. *Reduction in Personnel*

Regular convulsive therapy with the Reiter machine can be administered with a reduction in the number of staff personnel. Manual fixation of patients is unnecessary. The use of a gag is optional, inasmuch as the jaws remain closed throughout the convulsion.

4. *Easier Handling of Disturbed Patients*

Disturbed and un-co-operative patients are more easily handled. The hand-band containing the button electrodes can be applied more quickly than the usual appliances and without the patient becoming aware of the preparations for its application.

5. *Safe Combination Procedures Possible*

The compounding of unidirectional current, intravenous barbiturates and succinylcholine chloride is remarkably effective in creating a safe procedure for convulsive therapy employable in patients previously excluded from the standard modalities.

Probable Disadvantages of Apparatus

Probable disadvantages in the use of the Reiter machine are:

1. *Greater Complications of Machine*

The Reiter machine is more complicated than the machines utilizing alternating current. More training is needed for the proper use of the many techniques made possible by the machine.

2. *Possibility of Faulty Application*

Incorrect and awkward application of the electrodes may result in the patient becoming momentarily stunned—without a convulsion occurring and with the production of resultant fear and excitement. Amnesia for the treatment does not occur and the patient may thus become reluctant to submit to future treatments. The amnesia for the convulsion is important in evoking favorable responses to electric convulsive therapy.

Summary

1. This paper reports on the use of the Reiter Machine CW47C, utilizing unidirectional current, on Ward 50, Building 10, Brooklyn (N.Y.) State Hospital. An outline of the various methods employed is given.

2. A combination of thiopental sodium and succinylcholine chloride is used when indicated to diminish the intensity of the convulsions resulting from application of Position 3 of the machine. The addition of muscular softening to the advantages obtained by application of unidirectional current eliminates musculoskeletal complications and enables patients to receive convulsive therapy who were formerly excluded because of contraindications. The methods discussed and the use of the muscle-relaxant drug, succinylcholine chloride, in the treatment of the aged with musculoskeletal, cardiovascular and central nervous system complications diminishes the hazards of the convulsive therapies in these patients.

3. A greater number of patients than under usual methods can be treated by the various techniques described herein.

4. Additional data and information will be reported in the future, describing more fully the individual methods employed and the results obtained.

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AN INTRODUCTION TO THE STUDY OF THE NARCISSISTIC MORTIFICATION

BY LUDWIG EIDELBERG, M.D.

When one has chosen a special branch of medicine, it may happen that he becomes fascinated by a particular problem in the field, often minor, and one day realizes that many years have been spent in trying to record the results of studying it. This "overestimation" of the subject may be considered innocent as long as it does not interfere with one's sense of proportion, and does not cause a neglect of other aspects of theory and practice—in this case, of psychoanalysis.

The author has developed such an interest in the problem of "the narcissistic mortification," which, when experienced for the first time, may be defined as a sudden loss of control over external or internal reality, or both; by virtue of which the emotion of terror is produced, and a damming up of narcissistic libido or destrudo is created. The emotion of terror should be differentiated from the emotion of fear, in which a "defeat" is not experienced, but is anticipated as imminent. Whenever the emotion of terror is experienced, an external or internal agent has succeeded in, or is in the process of, overwhelming the total personality of the individual; and the sudden recognition of this loss of control over the external world, or over the self, produces the painful emotional experience of terror. As a result of this terror, the total personality tries to eliminate or decrease the defeat it has *suffered*.

For instance, threatened by a robber who is trying to remove my wallet, I may succeed in disarming him, and force him to flee. My emotion of terror is eliminated, and I enjoy an aggressive pleasure through having terrorized the robber. It seems that the terror I suffered at first has mobilized my aggression, which has succeeded in overcoming the aggression of the robber. In case I decide to surrender my money, I am able to save my life, and to decrease my terror, by giving up my possessions. My aggression is turned against myself; but, in addition, by mobilization of the sexual-instinct fusion, I have appeased the robber.

In addition to an attack from the outside, I may be attacked also from within. For instance, I may realize, after arriving at the theater, that I have forgotten my ticket. This parapraxia, which may be used as an illustration of the fact that a part of

myself is able to defeat my total personality, likewise may produce the emotion of terror. My aggression, mobilized by this terror, may succeed either in getting me another ticket, or, by being turned against the self, succeed in getting me sent home.

It may be helpful to continue this investigation of the problem with the help of a few concrete examples. First, one may try to separate a normal narcissistic mortification from a pathological narcissistic mortification. The individual who is forced by a gangster to surrender his money experiences an external narcissistic mortification. Another individual experiences an internal narcissistic mortification when, very much to his dismay, he finds himself overcome by his temper, during a scientific discussion, and starts shouting. It could be suggested that a normal person is never overcome by his emotions, and never forgets or loses anything. The upholder of such an exaggerated concept of health will be at a loss to find an example of a normal narcissistic mortification. This writer assumes that a normal adult usually is able to avoid being overwhelmed by his internal needs because he recognizes these various urges in time to bring about their partial discharge. However, this writer does not regard occasional outbursts of temper, or a parapraxia, as a sign of illness.

The study of pathological cases indicates that, following a repression, instinctual energy (libido as well as destrudo) remains fixated on an infantile object and an infantile form of discharge, and consequently cannot be gratified consciously by the total personality of the adult. Various defense mechanisms provide for a partial discharge of this energy, which takes place unconsciously, and interferes with the well-being of the person. The writer is in agreement with those psychoanalysts who assume that, besides the repression or denial of an infantile wish, the repression or denial of an infantile narcissistic mortification can be responsible for the presence of many defense mechanisms. Therefore, it appears necessary for the cure of a patient, to show him not only how his illness allows an unconscious gratification of an infantile wish, but also how, by being ill, he avoids the recognition of the realistic limitations of his power over himself and others.

It appears that the cutting of the umbilical cord in the newborn increases the craving for oxygen and produces also a narcis-

sistic mortification. The infant is no longer able to obtain the oxygen he needs from his mother (representing part of himself), but, in order to survive, has to get it from the external world. Before birth, the infant is not aware of the differentiation between himself and his mother. Whatever he requires from his mother is received, without the function of a conscious act of the total personality, without even the "act" of becoming conscious of the need. After the cutting of the umbilical cord, the newborn seems to experience some kind of shock, which helps him to mobilize the act of breathing. The need for oxygen is satisfied only after an unpleasant tension has produced a signal of danger, and has led to the discovery of a motoric action suitable for obtaining the necessary object (oxygen) from the external world. However, as the oxygen is available in unlimited quantities under normal conditions, the infant is able to obtain at once what he needs.

The child's experience of his inability to obtain oxygen after the cutting of the umbilical cord is referred to as an internal narcissistic mortification. As a result of this internal narcissistic mortification, the infant recognizes not only that he needs oxygen, but also that the act of recognition alone does not produce magically what he needs. It seems that, under normal conditions, the infant is able to accept this internal narcissistic mortification because he is able to mobilize the act of breathing without loss of time, and because the object he requires does not have to be sought out and fought for. Neither the friendly co-operation of the external object, nor ability to overcome the resistance of an external object and conquer it, are visible at this stage. However, the child experiences another narcissistic mortification on the oral stage, an external narcissistic mortification, whenever his mother is unwilling to co-operate, and he is not strong enough to force her to gratify his wishes at once.

An internal narcissistic mortification seems to help the child to realize the limitations of his power over himself. He cannot gratify his needs, and has to obtain what he requires from the external world. On the other hand, an external narcissistic mortification makes him recognize that his power over the external world is limited. Following an internal narcissistic mortification, the infant turns to the external world for help, whereas an external narcissistic mortification forces the child to turn to the

self, to learn to wait, and to change his activity and find other objects in order to get what he wants. If crying does not bring mother to his bed, he has to learn to call her, or to walk and fetch her. In such ways, these two kinds of narcissistic mortification appear to be helping the newborn to discover the limitations of his power over himself and the external world, and to develop mechanisms which increase his ability to deal with external and internal problems to a degree which makes survival possible. Perhaps it may be important in this connection, that a loss of power over the self usually can be tolerated, because the external world is available in consolation and compensation. On the other hand, loss of power over the external world may be acceptable because we do have the comfort of a certain amount of power over ourselves.

This writer does not know whether an internal and an external narcissistic mortification may have taken place simultaneously in all cases of neurosis. It appears plausible to assume that a child who experiences both forms of narcissistic mortification at the same time may be forced to use the mechanism of repression to avoid something similar to a loss of consciousness. However, instead of offering this suggestion as if it were an explanation of the phenomenon of repression, further clinical work is recommended. On the basis of experience, it appears that the study of the narcissistic mortifications, the differentiation of their various forms, and their thorough analysis, may play an important role in the theory and practice of psychoanalysis.

For certain reasons, usually referred to as traumatic events, some individuals manage to survive without conscious knowledge of the limitations of their will power. They often behave as if no action were necessary to gratify their wishes, and they have the illusion that nothing and nobody can interfere, or can have any right to interfere, when they decide to act. The fact that the external world is not controlled by our wishes produces, as has been said, a (so-called) external narcissistic mortification. On the other hand, the experience that the various parts of our body, and our personality, also have a certain independence, in spite of the fact that we communicate with them directly (without signals transmitted through the sense organs), leads to an internal narcissistic mortification. For instance, the child dis-

covers that he cannot run as quickly as the grown-ups, that he cannot see through the wall, that his needs must be recognized, that their gratification requires action, that his memory and his power of integration have their limits, and that he is not impervious to self-criticism.

The experience of these various narcissistic mortifications produces unpleasure, but is required for our training. If, for some reason, this unpleasure is too great, the individual is able to eliminate it from his consciousness by repression or denial. Whenever this process takes place, a neurotic defense mechanism will hide the presence of a narcissistic mortification from the patient, and he will behave as if he were omnipotent. Therefore, in the course of his analysis, this infantile omnipotence must be made conscious and destroyed.

It seems that whenever a narcissistic mortification is repressed or denied, the individual produces another narcissistic mortification, which is used to hide the original one, a process analogous to the mobilization of the opposite instinct-fusion (countercathexis), by means of which an original infantile wish may be kept unconscious. In other words, the narcissistic mortification which the patient represses or denies is kept from becoming conscious by a self-created narcissistic mortification. On the basis of clinical experience, this writer has the impression that an internal narcissistic mortification is kept unconscious by a self-created external narcissistic mortification, and vice versa.

For instance, a melancholic patient who wants to be cured must recognize that his acceptance of blame for everything which has happened is a fiction, that his masturbation did not produce the Second World War, not even the first, and that he is not responsible for the death of his girlfriend. In addition to his normal grief, the "bitter truth" which this patient succeeds in avoiding is that the death of his girlfriend, which appeared to have provoked his depression, is not his fault. What provoked his depression was the shock of discovering his lack of power. The fact that he had no influence upon, and bears no responsibility for, the death of the girl he loved, is not acceptable to him. His self-accusation means: "It is not true that I have no power over the external object. The truth is that I have no power over my de-

structive urges." This statement must be recognized by him as false.

In paranoia, the opposite idea is expressed: "It is not true that I cannot control my hate. The truth is that *you* cannot control your hate." The internal narcissistic mortification is denied, and the external narcissistic mortification—due to inability to control the hatred of an external object—is accepted. The melancholic patient prefers the unpleasure connected with his inability to control himself, while the paranoid chooses to accept the unpleasure caused by his inability to control others. Why? The only explanation this writer is able to offer is the probability that the experience of unpleasure cannot be avoided, but that an explanation which hides the real cause is acceptable because it helps to conceal the memory of the original trauma. In other words, the defense mechanism does not protect the patient from his emotion, but only conceals its real meaning. This phenomenon may be responsible for the strange, although well-known, fact that many people are prepared to accept all kinds of fantastic explanations under the condition that they are not true.

The paranoid patient behaves as if he were able to read the thoughts of other people directly, and as if the thoughts of others were able to influence him directly. He behaves as if the other person were part of himself, and as if he could communicate with him in the same way that he communicates with his own arm or leg. He does not believe his psychiatrist, who keeps on trying to prove to him that what he attributes to others is "really" his own wish. In such cases on the occasions when a successful analysis is possible, it is found that the paranoid fights against the recognition of what is true, because he cannot tolerate the fact that some of his wishes are stronger than his will power. Instead of trying to modify and sublimate what he objects to in himself, and does not want to be responsible for (since he believes that he could not change it anyway), he prefers to address it as if it were a foreign body which does not pertain to him, but belongs to someone else. It is assumed that in early childhood, he repressed the internal narcissistic mortification connected with the experience of not being able to control himself, and avoided the recognition of this internal limitation by "accepting" an external conflict instead. "They produce in me feelings which I hate

(not my feelings since *they* produce them) and then criticize me for having them." In early childhood, such a statement is partly true. The feelings of the child were mobilized (not created), by others, who did criticize him for having them, and often recognized the feelings even if the child tried not to show them. Under these circumstances, it seems as if the child is not given time to learn from his internal narcissistic mortification that, while we are not able to eliminate our feelings, we may develop methods to control them, or at least, not to show them. The mechanism of repression permits the child to keep both the infantile wish and the experience of a narcissistic mortification in his unconscious, achieving in this way a partial discharge of his infantile wishes, and retaining his infantile omnipotence.

As previously noted, the melancholic patient behaves as if he were responsible for all the disasters which matter to him. His wife died because he had masturbated as a child, or his girlfriend dropped him because he used to bite his nails when he was six. The fact that the death of his love object was the result of an illness, or of an accident, for which he could not be responsible, is not acceptable to him. In case he succeeds in overcoming his resistance in analysis, he will have to recognize that he is blaming himself for the death of his wife because he is afraid to admit that many of his actions have no influence whatsoever on others. The unpleasure of the external narcissistic mortification, which helps the normal person to discover what little power he has over the external world, has been repressed by the melancholic patient.

This writer does not assume that psychoses represent a "breakthrough" of elements from the id. Rather, he considers a psychosis to be the result of various defense mechanisms. However, the total personality (not the ego) of the psychotic patient appears to accept the end-results of such defense mechanisms uncritically, while the total personality of the neurotic patient either perceives them as a foreign body (symptom neuroses), or attempts to assimilate them into a neurotic character trait.

The problem of the narcissistic mortification becomes more involved when one examines the reaction of the total personality of the neurotic, which does not accept the results of the unconscious defense mechanisms. Perhaps the best example of an internal narcissistic mortification is a conversion symptom in a

case of neurosis. For instance, a patient who suffers from hysterical impotence will experience his initial loss of erection as an internal narcissistic mortification. On the other hand, a phobic patient, who is seized by his first attack of anxiety when he tries to cross the street to visit his girlfriend, appears to experience an external narcissistic mortification. However, he usually will admit that what forces him to stay home is not the bus in the street, but his fear of it. (Often, he is able to cross the street if he is accompanied by a little dog, a fact which helps him to recognize that his enemy is not the bus outside, but something inside.) Consequently, it appears that in symptom neuroses, the symptom produces an internal, and not an external, narcissistic mortification.*

To be cured, the impotent patient will have to recognize that his illness is not located in the "affected" organ, but is merely expressed by it, and that his acceptance of his inability to "produce" an erection protects him against the recognition of his inability to control his desires. His resistance against the recognition that his conscious genital wish represents only a mask, hiding an infantile phallic wish, is caused, not only by his "reluctance" to face the fact that he is still interested in his mother and wants to give her his urine, but also by the fear of admitting that his wish is—or rather was—too strong to be controlled. The phobic patient tries to regain control of his phallic wish by developing a neurotic fear. By being unable to visit his girlfriend on account of this fear, he tries not to have to deal directly with his infantile wishes to soil her. To be cured, he will have to recognize that his fear is not caused by the sense organ perception of the cars and buses in the street, but by his super-ego's prohibition against visiting his girlfriend.

Only by trial and error, do we discover the limitations of our power. We all have to learn slowly how to handle the body, sense organs, id, central ego, and super-ego, in order to achieve

*Certainly, a symptom-neurotic may be differentiated from a paranoid patient, who believes he is being persecuted by an external enemy. However, no experienced analyst will deny that there are many borderline cases, and that some psychotic patients may have varying degrees of insight into their illnesses, whereas some neurotic patients may have very little.

a harmonious compromise of these five parts of the personality.* Having divided the various forms of narcissistic mortification into two groups, internal and external, one may subdivide the internal narcissistic mortification further into five forms, depending on which of these five parts of the personality is primarily involved.

In all conversion symptoms, it appears that the patient accepts a narcissistic mortification from the body in order to avoid the recognition of a narcissistic mortification from other parts of his personality (chiefly from the id).

In phobia, a narcissistic mortification is accepted from the sense organs. The patient cannot control his terror when he perceives, or sometimes even when he imagines, the phobic object. By accepting this narcissistic mortification from his sense organ perceptions, he avoids the recognition of a narcissistic mortification from other parts of his personality—chiefly the super-ego. In order to be cured, he has to recognize that the repression of his super-ego from consciousness is of decisive importance.**

The study of neurotic character traits indicates that such a character trait protects the patient against the recognition of another form of internal narcissistic mortification. Whereas a patient suffering from a conversion symptom accepts an internal narcissistic mortification from his body, in order to hide the importance of his id, and the phobic patient accepts an internal narcissistic mortification from his sense organ representations in order to deny the importance of his super-ego, the character-neurotic *appears* to suffer from his lack of power over the external world.

Such a patient complained of not being able to establish relationships with girls. In his analysis, he had to recognize that what he described as his "bad luck" was the result of his own unconscious provocations. His neurotic character trait protected

*The author prefers to divide the total personality into five parts, instead of the three parts described by Freud, because the separation of the representation of the body and of the sense organs from that of the ego has proved valuable in his work with patients.

**In addition, many phobic patients have had traumatic experiences arising from an external narcissistic mortification, which led to their repression of the recognition of their lack of power over the external world. (The analysis of cases suffering from conversion symptoms reveals similar phenomena.)

him against the recognition of his real trouble. Only after he realized that the rejections he suffered were not accidental, but were the result of his defense mechanisms, was he able to progress in his analysis. At this stage, he accepted an internal narcissistic mortification, as due to his character trait, and ceased blaming the external world for his troubles. Having perceived that what appeared to be an external narcissistic mortification was caused by his behavior, he recognized these defeats as being due to his unconscious provocations, which he thought he could not control. However, these provocations were finally exposed in his analysis as the result of the ability of his unconscious ego to dominate his total personality. Instead of a fair compromise among the five parts of his personality, his ego had been able to dictate his behavior.

The unconscious infantile wish to urinate had produced impotence in the first patient, and something similar had been achieved by the phobia which prevented the second patient from visiting his girlfriend. In the case of the character neurosis, the infantile phallic wish was warded off by the provocation of a rejection from the girl, and in that way, there was interference with the possibility of a genital act. The patient's provocations represented the infantile wish, and its defense by what *appeared* to be a voluntary action. However, analysis disclosed that this "voluntary action" was the result of an unconscious defense mechanism, in which the decisive role was played by the ego. To be cured, the patient had to recognize the presence of his infantile wish, reject it, and develop instead a genital desire—in which the sexual urge is not the aim of soiling the partner.

This result was achieved only after the patient recognized that his neurotic character trait, which appeared to be the result of the action of his total personality, represented chiefly a victory of the ego, which dominated his behavior without trying to work out a conscious compromise among the various parts of his personality. If this patient had developed a psychosis, paranoia, for instance, he would have dealt with his infantile phallic wish by suffering from the hallucination that girls were making faces at him, and whispering, "Here comes the syphilitic lover!" In that way, he would have "accepted"—as an external narcissistic mortification—his inability to control the girls in the external world

and would have succeeded in concealing his inability to control his infantile wish.

Conclusions

1. A narcissistic mortification is the experience by the total personality of a sudden loss of control over internal or external reality, or both, accompanied by the emotion of terror. This unpleasure, caused by a damming up of narcissistic libido or destrudo, can be differentiated from the unpleasure which arises from the damming up of object libido or destrudo. In addition, "terror" is differentiated from the emotion of fear, in which a defeat is not being experienced, but is anticipated as imminent.

2. While the unpleasure due to object-instinctual tension is removed by a discharge of the object-instinctual energy, a narcissistic mortification is eliminated only by achieving the independent aim of regaining the lost control, and unblocking the dammed-up narcissistic libido. Consequently, a complete discharge of sexual, as well as aggressive, object-instinct fusions, may be experienced as unsatisfactory, because it leaves still unappeased the need to regain an *active* control over others and the self.

3. Internal stimuli, unlike external stimuli, usually appear as the result of a *slow* increase of tension; but, under certain conditions, they are able to surprise and overwhelm the total personality.

4. Detection of a narcissistic mortification (just as is the case with other elements in the unconscious) may be interfered with because of the mechanisms of denial and repression.

5. If the terror produced by the narcissistic mortification is not too severe, it results in a healthy, creative impulse, leading to the development of a co-ordinated action of the total personality, which attempts to solve the internal or external problem. Should the terror be too great, or last too long, the individual becomes "paralyzed" instead of being stimulated to activity, and must resort to denial or repression in order to protect himself against being overwhelmed completely by this peril.

6. Such denial or repression having taken place, a self-created narcissistic mortification is substituted for the original, "real" narcissistic mortification. This self-created narcissistic mortifi-

cation may produce fear, pain, and other forms of unpleasure, but never the emotion of terror.

7. Consequently, it is not surprising to find that each patient is using his defense mechanisms to protect himself from the experience (re-experience) of terror.

8. Various forms of narcissistic mortification may be differentiated as: (a) Whether conscious or unconscious; (b) Whether connected with sex or aggression; (c) Whether caused by internal or external forces; (d) If an internal narcissistic mortification; whether originating from the id, the body, the sense organs, the central ego, or the super-ego.

9. In psychosis, the patient appears not to differentiate between inside and outside, because his total personality accepts the exchange of an external narcissistic mortification for an internal one, and uses this exchange as a means of keeping hidden the "real" narcissistic mortification, and *vice versa*.

10. In neurosis, something similar happens, but the total personality usually distinguishes an internal narcissistic mortification from an external narcissistic mortification, and does not "accept" the end-results of the defense mechanisms, but recognizes the neurotic formation as pathological. In symptom neuroses, the symptom is recognized as an internal narcissistic mortification. However, in character neuroses, the neurotic character trait is assimilated, and is regarded as if it were the result of an action on the part of the total personality.

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INCIDENCE OF BRAIN TUMORS IN PATIENTS HOSPITALIZED FOR CHRONIC MENTAL DISORDERS*

BY MAURICE KLOTZ, M.D.

Introduction

The incidence of unsuspected brain tumors associated with chronic mental disorders is always of interest. The purpose of this paper is to provide additional data for use by students of this problem.

Mental Symptoms and Brain Tumor

I. *Frequency of Occurrence*

A. Mental symptoms associated with brain tumors usually occur in cases which have the following characteristics. The tumors are usually bilateral or supratentorial,[1, 2] are located in the frontal lobes, corpus callosum, temporal lobes or base of the brain,[1, 3-5] and exhibit slow growth rates, as in meningiomas, mixed tumors (epidermoids, cholesteatomas and teratomas) and oligodendrogliomas.[2]

B. Most patients with known brain tumors show minor reactive psychological phenomena at some time.[5] However, significant mental symptoms may be rather prominent, varying from 25 per cent to 50 per cent of the recognized cases.[5, 9-11]

II. *Incidence of Brain Tumors in Patients with Chronic Mental Disorders*

A. The incidence of brain tumors in patients with chronic mental disorders is difficult to evaluate for reasons involving the following factors:

(1) Lack of adequate neurological and laboratory (including postmortem) examinations,[12] due to:
   a. Insufficient or inadequately trained medical personnel.
   b. Lack of "brain tumor consciousness" in psychiatrically-oriented physicians.[12-15]
   c. Un-co-operativeness of the patient and the masking of changes that are caused by mental disorder.

(2) Insufficient focal and laboratory findings due to the nature of the tumor (rate of growth) and location.

*From the Veterans Administration Hospital at St. Cloud, Minn.

B. Actually reported incidence rates vary considerably from limits of 0.21 per cent to 1.7 per cent, given by Wolfson[16] for psychotic patients; 3.5 per cent to 13.5 per cent from state hospital necropsy data by McIntyre et al.[12] in reviews of literature. Author-estimates are 1.45 per cent by Gottsfeld[13] and 3.45 per cent by Hoffman.[14]

C. The number of brain tumors that are unrecognized ante mortem is put at "a certain small percentage" by Davidoff,[17] 14 per cent by Moore,[18] and from 31 per cent to 72 per cent by Waggoner.[19]

D. The incidence of brain tumors in general varies from 1 per cent to 3 per cent in large series,[19] with a figure of 2.1 per cent in 11 reports totaling nearly 45,000 autopsies.*

III. *Diagnosis*

Diagnosis of brain tumor is facilitated by improvement in diagnostic methods, by routine x-ray of skull, EEG, careful history and "brain tumor orientation" of physicians.[13]

IV. *Available Data*

The most nearly complete data available seem to be those of Hoffman[14] who found 3.45 per cent of brain tumors in 2,000 autopsies performed at St. Elizabeths Hospital, Washington, D.C., from 1922 to 1935, a period during which the autopsy percentage was over 99.

V. *Pathogenesis of Mental Symptoms Due to Brain Tumor*

General factors include:

A. Focal signs and symptoms, due to the effect of the tumor on adjacent brain tissue, by defect or irritative reactions.[14, 20]

B. General signs and symptoms due to increased intracranial pressure, toxins or circulatory disturbances.[14, 20]

C. Previous personality. This plays a distinct and variable role, and resultant mental symptoms are thought to be a reaction of the personality in the presence of organic disease.[1, 3, 4, 5, 11, 14, 21]

Wolfson[16] believes the different types of symptoms are due to:

A. Negative factors—suppression of receptor mechanisms in the posterior brain area resulting in mental retardation, loss of

*Table 2.

awareness, and lack of response to external stimuli which help generate thought processes.

B. Positive factors—suppression of emissive mechanisms in anterior brain areas resulting in excitation, delirium, maniacal states and euphoria.

Lewis[22] divides mental reactions as:

A. Response to organic type of reaction.

B. Response depending on the "mental constitution" and character of the individual, resulting in the various types of "functional" disorders.

Podolsky[23] quotes Papez concerning the importance of the gyrus cinguli and hippocampal connections with the hypothalamus. The conclusion is that no single structure is all-important and that all must be integrated for control of feeling and expression.

Procedure

I

A review of the literature and personal communications[24] with the New York state hospitals (relatively well staffed, with large numbers of patients) were undertaken with the aim of obtaining

Table 1. Summary of Brain Tumor Relationships to Mental Symptoms, New York State Hospitals

N. Y. State Hospital Source*	No. of Deaths	Post-mortems		Brain Tumors					
				Total		As Cause of Symptoms			
		Number	Per cent††	Number	Per cent†	Unlikely	Likely	Indefinite	Years covered
1	**1,897**	**525**	**28**	**5**	**1.0**	**1**	**4**	**0**	**7**
2	6,111	260	4	3	1.2	2	0	1	9
4	23,268	6,171	27	99	1.6	44	50	5	47
7	1,690	405	24	3	0.7	2	1	0	6
8	2,579	466	18	2	0.4	1	1	0	6
12	809	251	31	0	0	0	0	0	3
Total	36,354	8,078	22	112	1.4	50	56	6	78

*The numbers are arbitrary.

††Refers to number of deaths.

†Refers to number of postmortems.

sufficient data for reasonable conclusions on the incidence of brain tumors in hospitalized chronic patients.

Information from six of the New York state hospitals has been listed in Table 1. In this series, 112 (1.4 per cent) brain tumors were found in 8,078 autopsies. These autopsies were in 22 per cent of 36,354 deaths. Eighty-four (75 per cent) of the 112 tumors were unsuspected during life. Of the unsuspected tumors, 50 were considered to be unlikely, 56 likely and six uncertain as causes of the mental symptoms. The low average percentage (22 per cent) of autopsies to deaths leads to the question of how many more unsuspected brain tumors there actually were. Other available New York state hospital data—not covering the question of cause of symptoms—have been incorporated with the findings from the literature in Table 2, which gives the data in relation to investigators and periods of study.

Table 2. Brain Tumors in Relation to Investigators and Periods of Study (Literature and Personal Communications, with Three New York State Hospitals)

Source	Investigator	Years of Publication or Study	No. of Autopsies	Brain Tumors No.	Brain Tumors Per Cent
Ref. 19	Blackburn, I. W.	1884-1902	1,642	29	1.7
	Knapp, P. C.	1906	5,069	101	1.9
	Morse, M. E.	1915-1917	?	(46)	2.6
	Davidoff, L. M.	1903-1929	1,450	75	6.1
	Rudershausen, V.	1932	31,698	546	1.7
	Hoffman, J. L.	1932-1935	2,000	69	3.4
	Larson, J. L.	1937-1938	223	25	11.2
	Crumpacker, F. L., et al.	1943-1944	120	8	6.1
	Braatelien, N. T., et al.	1938-1949	1,168	54	4.6
Ref. 24	NY St. Hosp. No. 5	1947-1954	700	14	2.0
	NY St. Hosp. No. 6	1943-1953	510	5	1.0
	NY St. Hosp. No. 19		200	2	1.0
		Total	44,780	928*	2.1

*Omitting Morse's 46 cases, for which no figures of total autopsies were reported.

In the investigations reported in Table 2, there was a total of 44,780 autopsies from various investigators[19] and state hospitals.[24] In these 44,780 autopsies, there were 928 brain tumors found; an additional 46 were reported by Morse[18] but cannot be used to determine incidence, since Morse did not report the total

number of his autopsies. For the autopsies reported, the incidence of brain tumors is 2.1 per cent. For the question of recognition or nonrecognition ante mortem, still other figures must be taken, as the data are not given for all sources; for cases in which the information was available there were 96 unrecognized tumors out of 213, an incidence of 45.1.

This 45.1 per cent incidence of nonrecognition is in relation only to the Table 2 sources which supply information on the question of recognition. Five of the 12 Table 2 reports give no information on this point. The other seven cover this question, as do five of the six New York state hospitals reported in Table 1 (the sixth reported no tumors at autopsy). The five hospitals of Table 1 which reported finding brain tumors at autopsy, reported a total of 112, of which 84, or 75 per cent, were unrecognized ante mortem.

Table 3. Ante Mortem Recognition of Brain Tumors in Relation to Numbers Found at Autopsy

Source	Brain Tumors		
	Totals found at autopsy	Unrecognized ante mortem	
		No.	Per cent
Investigator (Ref. 22)			
Blackburn	29	21	72.4
Morse	46	14	31.0
Hoffman	69	23	33.3
Crumpacker et al.	8	3	37.5
Braatelien et al.	54	30	55.0
N. Y. state hospitals (Ref. 24)			
No. 1	5	0	0.0
No. 2	3	0	0.0
No. 4	99	82	83.7
No. 6	5	3	60.0
No. 7	3	0	0.0
No. 8	2	2	100.0
No. 19	2	2	100.0
Total	325	180	55.1

Combining from Tables 1 and 2 the 12 reports which gave information on the question of ante mortem recognition, Table 3 gives a total of 325 brain tumors found at autopsy, with 180 unrecognized ante mortem, an incidence for the whole series of 55.1

Table 4. Summary of Relationships of Brain Tumors to Mental Symptoms, VA Hospital Series*

	Significant Premorbid Personality Deviation			Date of Onset of signs and symptoms		Causal relationship of tumor to mental symptoms			CNS Tumor				Diagnosis (Per APA Diagnostic & Statistical Manual, Mental Disorders 1952)		
									Ante mortem				Ante mortem	Post mortem	
									Recognized						
Patient	None	Mild	Unknown	Neurological	Mental	Likely	Unlikely	Indeterminate	Yes	No	Type	Location		Remarks	Date
AJG	x	..	..	July 1941	Aug. 1942	x	..	..	x	..	Astrocytoma (operation Apr. 1942)	Left parieto-temporal	CBS** w/psychotic reaction assoc w/ new growth	Tumor left parieto-temporal area—residuals of astrocytoma; active pulmonary tbc	Apr. 1944
FAM	..	x	..	1932 (due to general paresis)	1932	..	x	..	..	x	Unknown	R. Frontal L. cerebellum	CBS assoc w/ CNS syphilis, meningoencephalitic type. Adenocarcinoma of thyroid	Small metastases of recent occurrence	May 1947
JWA	x	..	..	1929	1945	..	..	x	..	x	Exploratory opr. for suspected post-fossa tumor 1929, none found	III Ventricle	CBS assoc w/ disease of unknown cause (multiple sclerosis) w/psychotic reaction	Glioblastoma third ventricle	Sept. 1949
NWH	x	..	..	Jan. 1949	Jan. 1949	x	..	..	x	..	Astrocytoma (operated Jan. 1949)	Left Isle of Reil	CBS w/psychotic reaction assoc w/new growth	Not done	Nov. 1951

Table 4. Summary of Relationships of Brain Tumors to Mental Symptoms VA Hospital Series*—concluded.

Patient	Significant Premorbid Personality Deviation			Date of Onset of signs and symptoms		Causal relationship of tumor to mental symptoms			CNS Tumor				Diagnosis (Per APA Diagnostic & Statistical Manual, Mental Disorders 1952)	
									Ante mortem				Post mortem	
									Recognized					
	None	Mild	Unknown	Neurological	Mental	Likely	Unlikely	Indeterminate	Yes	No	Type	Location	Ante mortem	Remarks	Date
WFA	..	x	..	Dec. 1951	1947	x	..	..	x	..	Unknown	Pituitary and III ventricle	CBS w/psychotic reaction assoc w/new growth	Chromophobe adenoma, III ventricle area	June 1952
KJA	x	..	..	Sept. 1948	Sept. 1948	x	..	..	x	..	Epidermoid (operated Dec. 1948)	Right Frontal	"	Epidermoid Right Frontal	Apr. 1953
FAE	x	..	..	..	1937	..	x	..	..	x	Unknown	Vertex	CBS assoc w/ senile brain disease	Small flat calcified meningiomatous plaque 1x1x0.1 cm.	Apr. 1953
NCO	x	..	..	Oct. 1941	Aug. 1941	x	..	..	x	..	Astrocytoma (operated Mar. 1949)	Right Parietal	CBS w/psychotic reaction assoc w/new growth	Astrocytoma Right Parietal	Apr. 1953

*VA Hospital, St. Cloud, Minnesota
**Chronic brain syndrome

per cent. The division of these data among three tables is occasioned by the fact that some of the data of the sources reported by Waggoner and Bagchi[19] and those of some New York state hospitals[24] are not comparable and that some of the hospital data are not comparable among the institutions themselves. Relationships between tumors and mental symptoms, shown in Table 1, were not reported, for example, by the sources in Table 2.

II

The clinical and pathology records of the Veterans Administration Hospital, St. Cloud, Minn. from 1944 through 1953 were reviewed with special reference to the incidence of unsuspected brain tumors. The findings in the eight tumor cases determined at death are listed in Table 4. These include the diagnoses, relationships of tumors to possible causes of mental symptoms, recognition of tumors ante and post mortem, with types and locations of tumors. The data, with relationships to total deaths and total autopsies, are summarized by years in Table 5.

Table 5. Tumor Relationships*

	Deaths			Tumors					
		Postmortems		Ante mortem			As a cause of mental symptoms		
Year	No.	No.	Per cent**	Recognized	Unrecognized	Unlikely	Likely	Indeterminate	Total
1944	33	9	27	1	0	0	1	0	1
1945	42	4	10	0	0	0	0	0	0
1946	36	5	14	0	0	0	0	0	0
1947	33	24	73	0	1	1	0	0	1
1948	42	24	57	0	0	0	0	0	0
1949	42	18	43	0	1	0	0	1	1
1950	34	20	58	0	0	0	0	0	0
1951	35	23	65	1	0	0	1	0	1
1952	43	22	51	1	0	0	1	0	1
1953	52	35	67	2	1	1	2	0	3
Total	392	184	47	5	3	2	5	1	8

*VA Hospital, St. Cloud, Minn.
**Of total deaths.

Findings

1. Eight (4.3 per cent) tumors were found in 184 autopsies (in 47 per cent of 392 deaths) in a period of 10 years from 1944 through 1953 at the Veterans Administration Hospital, St. Cloud, Minn.

2. Of these eight tumors, three (37.5 per cent) were unrecognized ante mortem.

3. Of these three, two were unlikely as causes of the mental symptoms, and one was indeterminate.

4. The five that were recognized ante mortem were probable causes of the mental symptoms.

Table 6. Ante Mortem Recognition of Brain Tumors in Relation to Numbers Found at Autopsy; Summary from All Sources

From Table 3	No. of Brain Tumors Found at Autopsy	Unrecognized
Blackburn	29	21
Morse	46	14
Hoffman	69	23
Crumpacker et al.	8	3
Braatelien et al.	54	30
N. Y. State hospitals		
1	5	0
2	3	0
4	99	82
6	5	3
7	3	0
8	2	2
19	2	2
Total	325	180
From Table 5		
VA Hospital, St. Cloud	8	3
Total	333	183

III

General Results

1. The general incidence of brain tumors in 52,887 autopsies from the literature and correspondence[19, 24] was 2.0 per cent.

2. The combined totals of the relevant data in Tables 3 and 5 show that 183 tumors were unsuspected ante mortem (55.0 per cent) in a total of 333 found at autopsy by 13 investigators.

Discussion

The true incidence of unsuspected brain tumors is rather difficult to determine due to the variety of factors just discussed

in outline. This is especially true when a hospital has an inadequate staff and one lacking in "brain tumor consciousness." Nevertheless, some assumptions which seem reasonable might be made. The over-all incidence of brain tumors is about 2.0 per cent (Table 2). Hoffman's data[14] show 69 brain tumors, 3.4 per cent of 2,000 autopsies in an adequately-staffed hospital. Of these 69 tumors, 23 (33.3 per cent) were unsuspected during life. Since the percentage of postmortems was over 99, these findings would seem relatively accurate. From this, it might be deduced that the likely incidence of unsuspected brain tumors is about one-third of 2.0 or about 0.7 per cent. Since the incidence of meningiomas (the most common type of benign tumor) is about 15 per cent of all brain tumors, the likely incidence rate for this type of unsuspected tumor would be 15 per cent of 0.7 per cent or 0.1 per cent. When the number of meningiomas which are inoperable (due to location) or are merely incidental is deducted from this, it is likely that the incidence of unsuspected remediable brain tumors is less than one in 1,000 deaths in a hospital for patients with chronic mental illness. This theoretical estimate can be compared with actual data from New York Hospital No. 4. This showed 99 (1.6 per cent) brain tumors in 6,171 autopsies over a 47-year period from 1907 to 1954. The autopsies were 27 per cent of the 23,268 deaths. Thirty-two meningiomas were found in this series, 32 per cent of the total tumors. Of these 32 meningiomas, 10 (10 per cent of the brain tumors; 0.16 per cent of the autopsies; and 0.04 per cent of the total deaths) were unsuspected and were presumptively the main cause of the patients' symptoms. Therefore, the actual relationship in this series of the incidence of unsuspected symptomatic remediable meningiomas was about 1.0 in 2,000 deaths.

In the eight cases comprising the Minnesota VA hospital investigation, there was one unsuspected meningioma which did not cause the patient's mental symptoms or death. A second unsuspected case consisted of several small metastases to the brain from an adenocarcinoma of the thyroid (with no essential bearing on the patient's course of illness except terminally). The third case was somewhat unusual in that the patient developed neurological signs and symptoms at the age of 16. He was operated on

at the age of 19 for a suspected posterior fossa tumor which was not found.

He had a recurrent syndrome classified as multiple sclerosis for about 20 years, with enough of a remission to permit him to function as a truck driver for seven or eight years before entering military service. He had a recurrence of his symptoms in 1943 shortly after he was in the service, and these were characterized by remissions and exacerbations until 1945 when the symptoms began to follow a gradual progressive course. He was transferred from another hospital to the Minnesota institution in April 1949, following which he went steadily downhill. The neurological signs and symptoms were compatible with multiple sclerosis. At post mortem, an unsuspected small glioblastoma of the third ventricle was found.

Summary

1. A survey of the literature and personal communications indicate that the general incidence of brain tumors in hospitalized mental patients is about 2.0 per cent.

2. In a total of 333 tumors found at autopsy by 13 investigators there were 183 (55.0 per cent) unsuspected ante mortem.

3. A survey of the clinical and pathology records at the VA Hospital, St. Cloud, Minn. from 1944 through 1953 disclosed eight (4.3 per cent) brain tumors in 184 autopsies. The autopsies were conducted in 47 per cent of 392 deaths. Three of these tumors were unrecognized ante mortem; one of these was an incidental meningioma with no relation to the mental symptoms or disease course.

4. The likely incidence for remediable symptomatic brain tumors (meningiomas) is about 1: 2,000 deaths in hospitals for patients with chronic mental illness.

Veterans Administration Hospital
Downey, Ill.

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THE NEUROTIC STYLE*

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Translated by Walter Federn

"To know how to write" means: ability to communicate one's ideas in such a way that the reader comes to know them accurately and correctly. Yet, for the reader to understand and accept one's ideas correctly, and to be able to retain and assimilate them, more is needed than mere "correct" communication. Adequacy of educational background of the reader is one prerequisite, which does not depend on the writer, but which the writer must consider. It is more difficult to write for the general public than for one's fellow-professionals. Writing becomes the easier as a profession narrows into the writer's special field, his specialty, his special line within his special field. The most important condition, however, on which acceptance by the reader and his ability to understand depend, is encountered every day by the psychoanalyst: It is emotional resistance. It occurs in the patient and in the reader in like manner. To overcome it, a merely correct presentation of the subject matter is insufficient; if one wants his communication to be understood and not simply known, he must take account of the resistances. However, even the most precise argumentation can have effect only on those resistances that the reader is consciously aware of—as to their contents, cause and origin, and as to full intensity as well. If a reader's resistance is conscious, he can, in spite of it, understand the communication, reject it under the pressure of the conscious resistance, and rationalize the latter. But if the cause of the resistance is unconscious, the reader fails to understand what he reads.

In reverse, what has been said applies also to the writer.** If

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**EDITOR'S NOTE.—"The writer" throughout this paper refers, not to Dr. Federn, its author, but in general to anybody who writes. Contrary to this QUARTERLY'S usual rules, this paper is written in the first person to avoid the confusion which would be caused by reference to the author in the third person as "the writer."

there is an unconscious resistance in one's self against what one is writing, it becomes difficult to make one's self understood. However, in the case of neurotic resistances, i.e. of resistances in which the repression of the opposing counter-current has not been completely successful, certain distinct disturbances are produced, which have seemed to me to merit a close psychoanalytic examination. I was led to this study because faults in style resemble certain distinct types of disturbances which one finds during psychoanalysis as indicators of resistances of a particular type. It was inferred that these style-disturbances have a like origin; and it soon became certain that they were neurotic. To describe them specifically, however, would require both presentation of examples and their analysis. That would go far beyond the scope of this preliminary paper.

Whereas, for a direct investigation of normal style, the creation of a psychoanalytic theory of character and expression would be prerequisite, the method chosen here promises to give indirectly information about the normal style, too. As usual in psychoanalytic investigations, one first searches for the meaning and the genetic cause of the disturbances, in order to discern the normal as the broad intermediate among various abnormalities. However, since a neurosis not only alters one's mode of expression, but the character itself—at least in the customary wider sense of "character"—this communication also supplements investigations that are aimed at exploring character on the basis of style.

Some very great writers have made similar inquiries with polemic and educative intentions. Among German writers, Schopenhauer, Nietzsche, and Karl Kraus in particular have demonstrated the expression of immaturity, mendacity, cowardice, and meanness in the styles of various authors. Full of love and veneration for the wonder of the German language, those great writers arouse the language-conscience of those who have to write professionally. To be master of the rules of grammar, even of the laws of style, does not suffice. The author must have worked out an honest and decided opinion in what he has to say. The style of at least one distinguished man, Woodrow Wilson, has been investigated with the psychoanalytic method. The result of the investigation is so convincing that the method is certain to be

used again and improved upon. Hale, Wilson's secretary, felt he had reason to take revenge on the president for purloining his ideas. Therefore, he wrote "The Story of a Style." Among other things, he numbers the adjectives and attributive phrases, as compared with the numbers of verbs, and he counts gratuitous repetitions and empty abstract terms. He traces all the recurrent expressions which only paraphrase clichés bombastically; subjects the abstract terms and clichés chosen to an analysis of substance; and concludes that the whole bespeaks a lack of ideas, a predilection for suggestible phrases devoid of substance, and a strong narcissism which outweighs object-interest. An attempt is made to prove that the character of this writing style was already noticeable in Wilson's student days, and that the personality and the style developed on parallel lines. My own investigations are not polemical; on the contrary, once again—as is so often the case—the psychoanalytic method is to a large extent exculpatory, finding neurotic causes for writing badly, where Schopenhauer would simply state that ignorance, mendacity, and "scoundrelism" were at the bottom of it.

With the intervention of psychoanalysis, the neurotically bad style becomes something curable. Analysts have known for a long time that a complete change in the manner of writing is frequently acquired, as a secondary gain incidental to a cure. Relief from anxiety and the overcoming of ambivalence allow a truthful and unequivocal manner of expression in speech and writing. For some years I have directed the attention of a number of authors to their style neuroses—with good results. In these favorable cases, and even more markedly in refractory ones, defensive resistance appears first. Contrasted with the objective insignificance of a correction, the defense is so vehement, the sensitiveness at first so exaggerated, that, on this account alone, it is evident that the style disturbance is complex-caused. And, as in true psychoanalysis, resistance relaxes automatically in the case of an activated and intensified complex. As a rule, the style-neurotic—who at first is incredulous and even grows angry—finally becomes willing to discover the indications of neurosis in himself and even more readily in others. This is after the insight he was so loath to receive from me has come to him, as

if spontaneously and as if found by himself, after passing through his unconscious.

The material for my investigation was obtained through the many manuscripts that had to be read in my capacity as an editor. Such pieces of writing are less correct and polished than the final copy sent to the printer, although the same disturbances are found, if less numerous, in printed journals and books. The authors of the material discussed here are men and women who, trained in universities, have to guard the cultural treasure of science and seek to augment it. There are no poets and men of letters among the contributors who unintentionally became subjects of this investigation. Yet a number of papers could be said to be normal, not neurotic. If the majority of the papers showed quantities of neurotic disturbances, their authors are nevertheless, not necessarily neurotics, as measured by the standards of practical life. For reasons yet to be discussed, publication is especially likely to allow such complexes as do not ordinarily cause disturbances to become effective. On the other hand, we know that the neuroses are the most widely spread ills of civilization and that no one need feel ashamed of being accused of being neurotic. It is probably just as difficult to find the shirt of the un-neurotic person as that of the happy one (See Andersen's fairy tale).

The objection may be offered that our colleagues heed the matter and not the manner; that they lack interest in language and style, and take no pains at all to write well. However, the concern here is not with the excellence of the style, but with its freedom from disturbances. The existence of indifference toward the language has an influence that is the opposite of what the objection presumes. Many authors, prone to write neurotically, save themselves from doing so by the adoption of mimicry in writing, a prolix, impersonal manner which in its entirety serves the defense against any personal relation with subject matter and public. Once again, therefore, the social neurosis can forestall the neuroses of individuals. However, no one escapes the traps of his neurosis altogether or those of his actual conflicts that have temporarily the effect of a neurosis.

This has already been made plain through the "psychopathology of everyday life" discovered by Freud. Mistakes in writing,

slips of the pen, confusions, transpositions, omissions, repetitions arise from disturbing impacts of repressed emotions, just as do parapraxes in reading, speaking and listening. Such lapses, when abounding, imply an actually disturbed condition of the writer. Each—taken by itself—indicates the presence of a complex. For the writing author, these mistakes operate like valves, through which repressed forces find a way out without causing other disturbances of the style. He who pays attention to such parapraxes of his own, may—through their analysis—become aware of unconscious difficulties (or such as actually have become unconscious) that the subject matter has been causing him, before he permits his work to go to press.

I shall give only one example of wording that has been disturbed by a complex, and I choose a disturbance which must strike anybody, taking for granted but a modicum of psychoanalytic knowledge, and requiring no closer examination of the complex-disturbance. In a medical journal, the following sentence is found in a report on negotiations with a sickness-insurance fund: "A first conference took place where it appeared that Fund C is ready to accept the basic regulations settled in the agreement with Fund A and carried into the draft agreement with Fund B as well, which seem apt to safeguard and improve the system of free choice of doctors." Any reader will consider the sentence badly written. Could the report's author simply communicate here—without unconscious resistance—the state of the negotiations, he would write: "In the first conference, the representative of Fund C appeared ready to adopt the basic regulations which safeguard and improve the free choice of doctors, from the agreement with Fund A and the draft agreement with Fund B." In the original German, 34 words suffice in my version, while that of the author numbers 48. My version has a principal clause which states something new, and a subordinate clause which recalls what is known to be the theme. The author conveys the new statement in a triply-subordinated clause, and interjects a superfluous subordinate construction before the theme that is merely recalled.

The defense against the subject matter manifests itself in the delaying of the statement. As a compensation, an impersonal start is made with "it appeared that . . ."; and as long as possible, one

says nothing—in the guise of a factual statement. In cases accessible to personal analysis, one can obtain corroboration of this reasoning from the person analyzed.

We are faced here with an unsuccessful, but none the less incipient, phobic mechanism. It is unsuccessful because the will of the writer has effected the task of logical communication after all; his counter-desire was, instead, not to enter upon the subject. So the hesitating compromise develops, which expresses itself only in the style and not in the contents because the facts themselves indubitably had to be told. Whenever this is not the case, the counter-desire manifests itself in the wholly superfluous use of a modifying subjective form of the verb or in the insertion of a generalizing term in an individually definite statement. Instead of the modifying form, or—frequently—in addition to it, one of the words, "sure(ly), certain(ly), evident(ly), obvious(ly), undoubted(ly), absolute(ly)," is very often employed. Where the use of these terms may be actually warranted, it is almost never necessary to use them, as it is possible to convince the reader through argument. If, during psychoanalysis, a patient unnecessarily uses general terms, protesting or assuring expletives—usually in quantities—the psychoanalyst becomes aware, either instinctively or consciously, of the fact that an unresolved resistance is present. By way of analogy, one should be skeptical about the correctness of a written statement, or the certainty of the author with regard to what has been stated, if he employs protesting words without cogent reasons.

A recurrent appearance of one and the same pattern of neurotic style-disturbances should be regarded differently. In this instance, the individual disturbance is not necessarily related every time to the subject matter; rather, the disturbances indicate, jointly, the existence of a neurosis. Or they may show nothing more than that writing is a task full of conflicts for the author: that he is suffering from a permanent and generalized, or merely from an acute "communication-neurosis."

It is an invariable feature of such neurosis that resistance against what is to be written or against writing at all is unconscious. For example, ambition, vanity, narcissism, lust for power, hatred, disdain may manifest themselves in the selection of terms, in the handling of subject matter and attitude toward the public;

the style may be greatly influenced thereby, yet neurotic disturbances do not appear. He who is consciously ambitious writes without being disturbed by his ambition. However, precisely this conscious ambition, intermixed as it is with vanity, usually is still much greater than the author is consciously aware of. As the counter-current of resolution against appearing ambitious supervenes, the style, nevertheless, suffers a disturbing influence. In publishing of any kind, there is most often a struggle between desire to display one's self and shame (fear) to display one's self. Usually the conflicts between instinct and reaction subside after the first paragraphs have been written—partly because one has become inured to the situation of having to face a public, partly because the unconscious conflict has been settled in parapraxes and neurotic disturbances, until it becomes actual once more through approach to a complex.

The general psychoanalytic experience that it is the failure of repression which leads to neurosis is corroborated once again. Therefore, there are two ways of escaping the neurosis and the reactive self-betrayal: Either the repression must be nullified, or it must be successful. However, unexpectedly and in spite of all awareness, another failure may again disturb the order of the mind, and in the present case, the style—always, to be sure, only for weighty reasons. The disturbance that occurs at the start of writing ought to make many authors regard the first pages of their manuscripts as nothing but written soliloquies and exercises in composition: Since they do not always do this, it is precisely the first pages which are shot through with neurotic features. Therefore, one should not judge a piece of writing, whether published or unpublished, by its first part—and perhaps lay it aside, prejudiced against it by the uncertainty of the style. It is a general practice to begin a scientific article with the mention of other author's findings, explanations and theories. In this way, one joins his predecessors and has to report objectively. But only too often, even in introductions of this kind, subjectiveness causes noticeable disturbances. Hence it appears that there exists in writing the same self-consciousness—less marked, it is true, although it is perpetuated in print—that is felt and shown, even by experienced speakers, at the start of speaking. In both cases the public is the external factor, exag-

gerated narcissistic cathexis is the internal factor, which gives rise to the self-consciousnes and—if there is a narcissistic neurosis—to stage-fright. All self-consciousness ceases as soon as the narcissistic cathexis has been replaced by an object-libidinal one. The latter has to encompass the subject matter, as well as the hearer, or—to a less extent—the reader. Even in writing this is the more difficult to achieve when one attaches too much importance to relations with the public. As long as the two cathexes oscillate, one continues to be self-conscious because of them; and complex-disturbances prevail all the more easily.

Some authors are able to communicate something new readily, some others are incapable of doing precisely this; or they must force themselves strongly to do it; and psychoanalysis throws light upon this difference. After the beginning, the style is disturbed anew whenever one's knowledge becomes uncertain or when ideas belonging to others are passed off as one's own. Wide unscrupulousness in regard to stealing other people's ideas is no protection against this style disturbance. Here I touch on the subject of unconscious plagiarism, but I must conclude briefly, and I shall merely enumerate the most frequent writing disturbances—classified according to the mechanisms used. I leave undiscussed the special signs through which sadism, the anal component, and masochism, manifest themselves in style.

So far I have found the following disturbances: (1) incomplete condensation; (2) incomplete detachment from the previous subject matter; (3) the simple phobic mechanism; (4) the alternating phobic mechanism; (5) compulsive holding fast to a substitute concept, this including (6) exaggeration of the opposite; (7) escape into generalization; (8) inversion (an incomplete paranoid projection); and (9) superfluous interpolation of indirect presentation, usually caused by a trace of hysterical fantasy or by hysterical identification. This last form of disturbance uses various methods of synthesis.

As neurotic symptoms are due to certain mechanisms, so, likewise, are style disturbances; the latter, however, are not complete symptoms; the mechanisms are not complete. For the person writing, writing does, in an easy and relaxed manner, what psychoanalysis does for the person who is being analyzed. The fact

that one can indulge defense-mechanisms when writing prevents symptom-formation and yet permits—only after satisfying the needs of defense, of course—finding the correct association. He who writes is better off than he who speaks, for the latter must choose his terms decisively on the instant. That is why parapraxes happen more readily in speaking. Style disturbances affect the orator, too, their mildest form involving blurred or wrong accentuations, usually combined with expletive words and expletive sentences.

My investigations have not sprung from a desire to play the detective or to show psychoanalytic prowess. Correct expression in speech and writing is something we need and, likewise, is prerequisite for one's own honesty in working and publishing. To this end, there must, above all, be fulfilled the demand—voiced repeatedly by pedagogic authorities—that from the first grade to academic positions no one should be constrained to write on matters he is not yet mature enough to deal with, even if for that reason the school "composition" in its present form has to disappear altogether. School writing should especially not be graded,* for the mark constrains the pupil to write anyhow—when he has nothing to say.

Individually, analysis of style disturbances makes it possible for every writer to become aware by himself of the fact that he is disturbed by a deficiency in factual knowledge, or by emotional bias, or that his struggle has not yet led him to clarity.

*In the Austrian elementary schools compositions are no longer [1930] graded.

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CHLORPROMAZINE MAINTENANCE THERAPY DURING PREGNANCY AND CONFINEMENT*

BY ELSE B. KRIS, M.A., M.D., AND DONALD M. CARMICHAEL, M.D.

In a follow-up study of about two years on a group of 250 patients released on convalescent care from various state hospitals in the New York metropolitan area, 14 women became pregnant some time after their release from hospital. Before discussing the findings on them, some general points require to be reviewed.

Reports on hospital admissions reveal that between 2 and 10 per cent of women entering mental hospitals suffer from psychosis appearing at the time of pregnancy or during or after childbirth. Bleuler[1] denies the existence of a special puerperal psychosis, including in this term psychosis appearing during pregnancy, lactation, and up to six weeks following childbirth. However, he feels that a latent schizophrenia can become manifest or be exacerbated during these periods.

Generally, the literature on psychiatric complications arising during pregnancy and the puerperium reveals that almost all authors agree that the rapid and dramatic changes in the course of normal life processes frequently are accompanied by emotional reverberations. While some authors stress the possibility of an endocrine origin of mental disturbances at this time of life, others point out that there are few factors to suggest that changes in the endocrine functions as such are of essential importance.

Henderson and Gillespie,[2] along with others,[3, 4] consider pregnancy and childbirth to be immediate precipitants of schizophrenic reaction types. There seems to be general agreement that persons with a history of earlier emotional and personality disorder are liable to become overtly psychotic in reaction to the stress of child-bearing and childbirth.

Thus, the risk of recurrence of a psychosis in the case of subsequent pregnancy and parturition has been generally acknowledged; and various authors agree that women who have already had mental disorders are particularly predisposed to the development of psychotic reactions at such times. This realization has led to a search for some form of prophylaxis. As a result, insight

*Paper read at the Downstate Interhospital Conference at the New York State Psychiatric Institute, New York, N. Y., April 30, 1957.

type of psychotherapy, supportive psychotherapy and prophylactic electric shock therapy[5, 6, 7] have been recommended to prevent such breakdowns.

Though chlorpromazine has been widely used in the treatment of nausea and vomiting in pregnancy, hardly anything so far has been recorded on the use of this drug for the prevention of psychiatric complications during pregnancy and childbirth. But, here and there, concern has been voiced as to what effect chlorpromazine administration might have on the mother and particularly on the infant.

Animal tests on bitches and on young rats have shown that although their offspring had received chlorpromazine *in utero* and through their mother's milk, they were normal in all respects. Although thorazine was administered to rats through three successive generations, no detrimental or pathological effects were observed.*

While Dickel and Dixon[3] report that in a group of 82 patients on chlorpromazine therapy they have observed one abortion and one near-abortion, these authors also state that "this may have to be explained as sensitivity or allergic reaction."

In a personal communication, Gellis[8] reports on his experience with the use of thorazine during pregnancy: "We have studied about 100 infants and mothers who have received short-term and long-term therapy during pregnancy, ranging from small doses to very large doses, and have found absolutely no evidence to date of untoward effects. Our chief study concerned bilirubin curves during the first week of life."

The group to be reported in the present paper consisted of patients who had been treated with chlorpromazine during hospital residence. While some of them were continued on chlorpromazine maintenance therapy following their release from the hospital, drug therapy had been discontinued on others before release.

Thirteen of these 14 women were diagnosed as having some type of dementia praecox, one as having a psychosis due to alcohol. Five patients in this group had previously suffered psychotic breakdowns after childbirth. Among the 14 patients, there had been, so far, no abortions, and no miscarriages.

*Report from Smith, Kline & French Pharmacology Section (Mr. Macko).

It was interesting to observe that although most of these women in previous pregnancies had suffered from more or less severe nausea and vomiting, none complained of these symptoms during the pregnancies reported here. This seems to confirm the findings of others who noted the successful control of such symptoms with chlorpromazine.

All of these women have now given birth to normal, healthy children at term. One woman delivered five weeks before her time, but it was noted that her four other children had all been born prematurely.

While eight of the women were on maintenance therapy, receiving between 50 and 150 mg. of chlorpromazine daily, as recommended upon their release from hospital, six were not receiving any medication at the time their pregnancies became known. One of the latter showed symptoms of rapid relapse in the fourth month of pregnancy and had to be returned to the hospital. In consequence, the other five were placed on maintenance therapy of 50 mg. of chlorpromazine daily. One, however, took the medication regularly for only a few weeks, then only sporadically, and finally stopped altogether. Two weeks before term, she became severely disturbed and hallucinated and had to be rehospitalized.

As soon as the fact of a pregnancy was established, contact was made with the family physician or the maternity clinic taking care of the woman, reporting the amount of chlorpromazine each patient received. Regular laboratory tests were done, and the patient's aftercare clinic was notified about the results. A letter was also written to each hospital where a delivery was to take place, requesting that each patient be continued on her given chlorpromazine dosage during confinement. The fullest co-operation was received from all these agencies. Thus, the women who have come through pregnancy without symptoms of psychotic relapse were continued through childbirth and postpartum on maintenance therapy. Seven of these women nursed their babies. Blood counts and liver function tests were satisfactory in all of the cases. The infants, now aged five to 16 months are found to be healthy and show normal behavior and development.

The following brief case histories tend to illustrate better than any statistical evaluation could do, the role chlorpromazine main-

tenance therapy has played in the prevention of renewed psychotic breakdown in individuals with histories of previous psychoses.

The first two illustrate how institution of maintenance therapy appeared to have prevented renewed psychotic episodes in women who, before, had become psychotic after childbirth.

Case 1

B. A., now 27 years old, diagnosed as having dementia praecox, catatonic type, was married at 18 and had three boys when she gave birth to her first daughter after the pregnancy reported here. Soon after the birth of her second child in 1952, she had become irritable, could not control herself, cried frequently, saw snakes on the floor and reacted to auditory hallucinations. She refused to eat and was finally hospitalized from September 1952 to January 1953. In May 1954, she gave birth to her third child and some time later became excited again, complained about insomnia, and was admitted to the hospital for a second time, staying there until November 1955. Chemotherapy had been discontinued at the hospital several weeks before her release.

In May 1956, B. A. was found to be pregnant again, and in view of her previous history was placed on 50 mg. of chlorpromazine daily at bedtime. She came through her pregnancy without any untoward symptoms and gave birth to a normal baby girl on December 23, 1956. The baby, who weighed seven pounds, four ounces at birth, weighed 11 pounds at four months and was found to show normal general development. The mother has been able to take care of her children and her household and has shown good adjustment so far. She has been continued on maintenance therapy to this date.

Case 2

P. E., now 36 years old, was married in 1944 and gave birth to five children in short succession. In 1951, she started to complain about insomnia. She said people disliked her and were against her, and became gradually more and more argumentative and assaultive until she was finally hospitalized that same year, with a diagnosis of dementia praecox, paranoid type. During four years of her hospitalization her children stayed in various foster homes. She was released on convalescent care in October 1955, with the recommendation that she be kept on a maintenance dosage of 200 mg. of chlorpromazine daily. She made a good adjustment, and was co-operative and reliable about taking her medication. Gradually arrangements were made for the return of her children to the home. In March 1956 she was found to be pregnant again. Maintenance therapy was continued. In October 1956, she gave birth to a seven-pound

girl whose weight more than doubled in six months. The baby shows normal development, the older children are well-kept, and the patient herself, who is still continued on maintenance therapy, is happy, shows good insight and good adjustment.

The third case illustrates how a patient with a history of previous psychosis, not kept on chemotherapy, showed rapid onset of psychosis during pregnancy.

Case 3

M. S., 28 years old, was diagnosed on her first hospital admission in 1947 as a case of dementia præcox, hebephrenic type. She was released in 1950 and gave birth to her first child—conceived out of wedlock—in 1952. Shortly following the birth of this baby, she became psychotic again and had to be rehospitalized. She was again released on convalescent care in September 1955, after successful treatment with chlorpromazine. Chemotherapy had been discontinued at the hospital prior to her release. In January 1956, she was found to be pregnant again (she had been married shortly after her release from the hospital in 1955) and shortly afterward she was seen to neglect her personal appearance. She became irritable, then quickly became disturbed, and, in consequence, was returned to the hospital.

Summary

Five out of 14 patients who became pregnant while on convalescent care had previously suffered psychotic breakdowns following childbirth.

Eight of the 14 women were continued on chlorpromazine maintenance therapy following their release from the hospital, and throughout pregnancy and puerperium.

Of the remaining six not on medication when their pregnancies became known, one woman had to be rehospitalized in the fourth month of her pregnancy. A second woman, who—after institution of maintenance therapy—failed to take the medication, relapsed two weeks before term. After maintenance doses were instituted, the other four women continued to take them regularly.

No infant born showed signs of abnormality at birth, and all are developing normally.

Though further observation on a larger scale is needed, the present study seems to indicate that maintenance therapy can safely be carried on through pregnancy and the puerperium.

Chlorpromazine therapy throughout pregnancy and the puerperium as a preventive measure in those cases where the danger of renewed psychotic breakdown exists seems to have definite value.

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HYPOTHERMIA (COLD NARCOSIS) IN THE TREATMENT OF SCHIZOPHRENIA*

BY THOMAS I. HOEN, M.D., ALDO MORELLO, M.D., AND FRANCIS J. O'NEILL, M.D.

This paper is a preliminary report of the first 18 months of a research program conducted at Central Islip (N.Y.) State Hospital into the treatment of schizophrenia by hypothermia.

Schizophrenia, as a disease, has shown singular lack of satisfactory response to treatment. In the assault on it, a variety of therapeutic modalities have been employed, including narcosis produced by a variety of agents. The earliest records of psychiatric procedure include attempts at treatment of chronic regressive psychosis with sleep-producing agents. Whether this approach is rational, has not as yet been established. This does not, however, lessen professional interest in this type of treatment. Twenty years ago prolonged narcosis induced by sodium amytal and other barbiturates was in vogue, with encouraging results reported by some investigators. After several years of use, however, sodium amytal narcosis almost completely disappeared as a therapeutic approach to schizophrenia. More recently, patients have been treated, in many cases successfully, by electric current narcosis.

Just why a state of narcosis has a tendency to produce improvement in schizophrenic symptomology is not well understood. One interesting theory is that, during the state of narcosis, changes take place in the enzyme system of the central nervous system, tending in some obscure way to reverse the schizophrenic process. The present report is not an attempt to present obscure theory but to recount experience with cold narcosis.

Some workers have attempted to use chemical means to produce a state in humans closely resembling the hibernation of certain animals. Animal hibernation produces sleep, plus a marked reduction in body temperature. In human beings it has not been possible to produce a state of hibernation for any extended period. Such extended hibernation, however, may be a legitimate aim in the therapy of psychosis. Before using cold narcosis in the writer's patients, a series of experimentations was carried out, with dogs

*From Central Islip State Hospital, Central Islip, N.Y. Read at the downstate interhospital conference at the New York State Psychiatric Institute, April 2, 1956.

as subjects. It was found possible to reduce the body temperature of a dog below 80° Fahrenheit and maintain this for an average of 48 hours, with survival of a majority of the animals. In a few cases it was possible to reduce the dogs' temperatures to 76° Fahrenheit and keep them there for 10 hours without untoward effect. As a result of animal experimentation, it was concluded that producing a state of cold narcosis carried with it much less risk to life than had previously been supposed.

An examination of the literature indicates that as early as the sixteenth century, a French physician, Simon Fissot, recommended cold baths in the treatment of mental disease. These probably were intended as sedatives, rather than as attempts to lower body temperatures. In 1934, Cameron reported on investigations of the thermo-regulatory characteristics of schizophrenic patients. He concluded that these patients have accurate and intact mechanisms of heat control. In 1935, Gottlieb and Linden,[1] by comparison of rectal and oral temperatures, concluded that schizophrenic patients appeared unable to comply normally with the homeostatic principles of heat regulation and expressed the belief that the heat control mechanism of the schizophrenic patient is somewhat deranged. In 1941, Talbott and Tillotson[2]—under the influence of research by Fay on cold narcosis in the treatment of cancer—used hypothermia in 10 schizophrenic patients. In eight of the 10 patients, temperatures were reduced below 85° F. Refrigeration below normal was maintained for as long as 38 hours, and in some cases, as long as seven hours below 80°. These observers reported temperatures as low as 74°. One to three treatments were given, with intervals between treatments of one to three months, when they were repeated. These authors reported "persistent" modification of the mental picture in four of their 10 patients. Goldman and Murray,[3] working at the Long View (Ohio) State Hospital in 1949, treated 16 patients with hypothermia. In some of these cases, body temperature was maintained as low as 80° for up to 60 hours. According to these observers, the mental changes noted were "invariably disappointing."

In an 18-month period, 13 patients (nine men and four women) were treated with cold narcosis at Central Islip State Hospital. A total of 65 hypothermia treatments were applied, an average of five to the patient. Six patients had six treatments, one had seven

and one had 10. Treatments were usually given at one-week intervals.

Method

A refrigerating unit has been employed, which permits the circulation of a fluid through coils in a rubberized blanket, placed under and over the patient. The temperature of the fluid can be controlled by the operator through a range of 20° to 148° Fahrenheit. During the entire procedure, rectal temperatures are constantly recorded on a Weiss clinigraph. A specially-built mercury thermometer, with a range between 60° and 105° Fahrenheit is used. Anesthesia has always been employed during the induction of cold narcosis. Different methods of anesthesia have been used to find a technique which would avert shivering without causing marked depression of vital functions. Pentothal sodium was employed in 12 instances, by intravenous drip with intubation. In one case, curare was administered with the pentothal. Anectine was used in 18 instances. High spinal anesthesia up to C4 was utilized in 23. Intubation was a uniform procedure. Muscular relaxants, such as curare and anectine, were found useful in controlling the shivering.

The time required to reduce body temperature to 86° Fahrenheit—the point at which a state of cold narcosis usually developed—varied, depending upon the subject and the anesthesia used. When continuous spinal anesthesia was employed, it usually required two hours to reach the point of cold narcosis. When intravenous pentothal drip and anectine were employed, the time was usually increased to over three hours. When the body temperature dropped to 85°, the refrigerating machine was turned off, but the fluid in the tank and in the coils of the blanket was permitted to remain. In most cases, the body temperature tended to continue to fall for an hour, until it reached 82°, where it would become stabilized for a similar period and then commence to rise gradually. If serious EKG changes were observed during this period, the fluid in the tank and blanket would be warmed, and circulation of the fluid commenced. In this way, body temperature could be raised to approximately 91° Fahrenheit in about two hours. Here, anesthesia, if still in use, was discontinued and the patient returned to bed to permit gradual adjustment of body temperature to a normal level. At this point, shivering was usually intense.

In cases where no serious EKG changes were observed, maintenance of body temperatures at approximately 82° might be permitted over a more extended period. By careful observation of vital functions, serious complications have been avoided in this series of cases.

All patients received chlorpromazine before or during the period of cold narcosis. Some patients had single intramuscular doses of 100 mg. 30 minutes before the hypothermia procedure was started. In some cases, repeated administrations of chlorpromazine to totals up to 500 mg. were used. Rapid fall of body temperature to a level of cold narcosis was accomplished in all cases. The average lowest body temperature observed was 83.2° F. The average time during which body temperature remained below normal was 10.9 hours. The average time during which body temperature was below 90° was 3.9 hours. Body temperature as low as 78° was recorded in some instances. During the course of hypothermia, a wide variety of clinical and laboratory examinations was performed. It is not the purpose of this preliminary report to discuss the physiological response to cold narcosis. It may be of interest to note, however, that during the course of treatment the following blood determinations were made at stated intervals: hematocrit, blood sugar, blood urea nitrogen, chlorides, prothrombin time, circulating eosinophils, blood sodium and potassium, oxygen and carbon dioxide content. Urine excretion of 17 ketosteroids over 24 hours was also determined before and after treatment. Routine kidney function tests were also done. Routine EEGs and EKGs were taken. Basal metobolic rates were measured at frequent intervals during the treatment. Electromyographic studies were also made in most cases.

Selection of Cases

All of the 13 subjects were hospitalized patients. Ages ranged from 25 to 53 years. Two patients were between 25 and 30, two between 35 and 40, three between 40 and 45, two between 45 and 50, and two over 50. Twelve of the patients treated in this period had clinical diagnoses of dementia praecox: five of hebephrenic, four of catatonic, and three of paranoid type. The thirteenth pa-

tient was epileptic, with a paranoid, hallucinatory type of illness, closely resembling schizophrenia. In all cases, the disease processes had been in existence for many years. Five patients had been hospitalized between two and three years, one over six years, one over 12, five over 16, one over 17. All patients had received extensive treatment, 10 having had electric shock and psychosurgery. It can be seen from this that only patients with seemingly hopeless prognoses were treated.

The writers have since engaged in treatment of more hopeful cases with cold narcosis. It is hoped that continued use may open up a new avenue for treatment of this disease.

Psychiatric Response to Treatment

None of the patients treated has shown sufficient improvement to permit release from the hospital. Transitory improvement in aggressive conduct was observed in most cases. The relatives of some patients have indicated that they felt the patients were improved. This type of alleged improvement is difficult to evaluate. It is impossible for the writers to claim that this type of treatment has successfully influenced the disease process in any of the 13 cases.

Physiological Observations

Changes in basal metabolic rates were found to be significant at low body temperatures. From normal values, the BMR's dropped to between —15 and —25. The drops in oxygen consumption paralleled the lowering of temperatures. During hypothermia, the most significant blood change observed consisted in a slight rise of hematocrit—usually about two points, a drop of circulatory eosinophils and an increase in blood sugar levels, very often exceeding 250 mg. per cent. Blood sugar levels of 290 mg. per cent were not unusual. The rise in blood sugar levels requires some interpretation as many of the patients undergoing this treatment received continuous intravenous drip of glucose and saline. This subject has not been completely explored as yet, but it is the writers' impression that the rise in blood sugar was due only in part to the glucose received by vein. The writers believe that hypothermia per se produces a spontaneous rise in blood sugar level. An increased excretion of 17 ketosteroids has been noticed.

Changes in body electrolytes are under study, but no conclusions can be drawn at this time.

Continuous electro-encephalographic recordings were made. At first, the writers were much impressed by the extensive alterations observed in the EEGs. Decreased frequency and amplitude of waves to the point of almost complete cessation of the wave pattern was observed in some cases when the body temperatures reached low levels. Careful evaluations of these findings have led the writers to believe that most, if not all, of these changes have resulted from anesthesia rather than hypothermia. The observations in this regard have not as yet been completed.

Electrocardiographic studies were made at frequent intervals in all cases. Evaluation of all of the tracings has not been completed at this time. Disturbances in conduction and rhythm were seen at low temperatures in most cases. In some cases, temporary bundle branch blocks were noted. All of the electrocardiographic abnormalities reverse themselves after the return of body temperatures to normal.

Conclusions

Thirteen patients, nine men and four women, suffering from chronic regressive psychoses, have been treated by significant reductions in body temperatures to a point of cold narcosis for periods of several hours. All of the patients so treated had psychoses in existence for many years with histories of many years of hospitalization. Clinical results in the patients so treated have not been significant, although temporary improvement was noted in a few cases. Studies of physiological response to the lowering of body temperature have been an important phase of this investigation. Complications of a serious nature have not been observed.

Although the technique of lowering of body temperature requires expensive apparatus and careful medical and nursing care of the patient, the writers are encouraged by the initial observations to continue this approach to the treatment of schizophrenia by the application of the technique to patients with more hopeful prognoses. It is hoped that the work now being carried out at Central Islip may result in the development of a simplified method, whereby it may become possible to treat the schizophrenic patient

with cold narcosis so as to produce a state resembling animal hibernation.

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PSYCHIC DRIVING: DYNAMIC IMPLANT*

BY D. EWEN CAMERON, M.D.

In an earlier communication, the procedure of psychic driving has been described in some detail.** Briefly, it is the exposure of the patient to continued replaying, under controlled conditions, of a cue communication derived from one of the original areas from which his current difficulties arise. A major consequence of such exposure is to activate and bring progressively into his awareness more recollections and responses generally from this area. The ultimate result is the accelerating of therapeutic reorganization.

It was early noted that continued replaying of a cue communication sets up a persistent tendency in the patient to act in a way which can be predetermined with respect to its general characteristics. In other words, by driving a cue statement one can, without exception, set up in the patient a persisting tendency for the cue statement and other components of the relevant "community of action tendencies" to return to his awareness. This tendency has been termed the dynamic implant. By "community of action tendencies," a group of related activities and attitudes is meant—such as, for instance, those existing between the patient and his mother, or those related to his feelings of inadequacy.

Since, clearly, this continuing result of psychic driving might greatly enhance its effects, considerable study has been directed to the conditions controlling the setting up of the dynamic implant and to the effects of the implant. The findings are reported herewith.

Procedure

The dynamic implant may be set up either by autopsychic or heteropsychic driving. The first procedure consists in the repeated playing of a cue communication made by the patient. The second is the replaying of a communication devised by the therapist from his knowledge of the patient's dynamics.

*From the Allan Memorial Institute of Psychiatry, Montreal, Canada. This paper was read at the 111th annual meeting of the American Psychiatric Association in Atlantic City, May 11, 1955.

**Cameron, D. Ewen: Psychic driving. Am. J. Psychiat., 112:7, 502-509, January 1956.

Since autopsychic driving is more easily carried out, this report has been based upon that type, with implants set up by means of periods of 10 to 30 minutes' driving—repeated, if necessary, once a week.

Preferably, the communication should deal with one topic only and should not be longer than about 20 seconds. In practice, the material is derived from a psychotherapeutic hour which has been recorded on magnetic tape. It has been found useful to transfer these communications to 14-inch records and to reproduce them through a high fidelity phonograph adjusted for continuous playing.

The communication should be derived from a community of action tendencies which are of basic significance to the patient. Moreover, it is most effective if taken from the time of origin of this communication. It may, for instance, be selected as expressive of one of the great formative relationships of the earlier part of the patient's life, as in the following communication, in which the patient is reliving her early relationships with her mother:

"Everything about me was wrong—the way I acted, the way I spoke, the way I dressed . . . everything, everything I did. Many times she [the patient's mother] would just talk and talk and talk, and . . . well, I can't go thinking up these things."

Or it may be drawn from a long-continuing climate of rejection, insecurity, or hostility which prevailed during a critical early period in the patient's personality growth:

"Now that I think about it, seems to me that my parents had me just to even up the family . . . not because they wanted me . . . because of course their attitude towards me . . . Gee, I don't remember the boys getting as much hell as I did . . . or my sister."

The significance of the cue communication must be assessed, not only in terms of the therapist's conception, but also in terms of the patient's response. The two do not necessarily coincide. The second is the more realistic guide.

The following is an example of the patient's immediate response to the implanting of a cue communication. For the purposes of presentation, a response at the upper level of intensity has been selected. The case is that of a woman suffering from anxiety

hysteria with many conversion symptoms. The cue communication ran as follows:

"I stayed home all the time when my mother lived. I stayed with her . . . didn't want to leave her. I was always left staying home with her and . . . I didn't have any life like all . . . the other girls."

On the first implanting on January 4, 1955, the patient, who had come in that day and rather gaily said that she had nothing on her mind and nothing to talk about, was silent. At the end of *five minutes* she said, "It makes me nervous, you'd better stop it . . . it makes me feel bad." She was now restless and anxious and very different from the gay person she had been when she came at the beginning of the hour. At *eight minutes*: "Doctor, doctor, I've had enough, please stop it." Holds head. *Nine minutes*: "That's enough. It makes me nervous to hear that." *Ten minutes*: "Why don't you stop it, doctor. I've heard enough. It is always the same."

At the end of 10 minutes, the patient was asked: "What did you think about it?" *Answer*: "It made me nervous all over again. Everything hurt me all over as it did before. My voice sounds like I am going to die." She then went on to bring out a great deal of new material, saying: "My mother almost might not have had me, I was so quiet as a child." And again: "After my mother died, my father gave up his music and began to drink. I tried to take her place for him. I wanted so badly to please him and I cried every night and I tried to carry on. I kept everything very much to myself. My father was like a child. I had no friends by the time my mother died, I had stayed at home so much."

If the cue communication evokes too great a response from the patient, it will, in a measure, defeat its own purpose, since defenses will be erected which may take a considerable time to reduce.

The writer would like to state here clearly an answer to a question which he is sure will arise in everybody's mind. In two years of exploration into this new field, covering more than 100 cases, in only one has there been seen a possible persisting trauma resulting from the implant; and even here, current events —such as the breakdown of a love affair and threatened deporta-

tion—undoubtedly contributed to, if they did not cause, the panic state through which the patient passed.

As an example of a cue communication which is not well chosen, the following is presented. It was selected earlier in the writer's experience and, as can be seen, is drawn from a period when the patient's personality structure was already well developed; it is representative of current stress and is not expressive of those forces which brought about a formation of the early neurotic traits which have got the patient into continual difficulties through her insatiable seeking for affection and endless understanding:

"Well . . . because . . . Robert doesn't care . . . and I have always thought I would have it in time [a house] . . . and I have been very patient . . . and I don't know whether it has just suddenly . . . I realize now it is all so hopeless, thinking about it."

After considerable experimentation, two additional procedures which facilitate the establishment of the implant have been found. The first is that the sound should be conducted to the patient's ears through headphones. This causes the patient to experience the driving with much greater impact, the more particularly since he frequently describes it as being like a voice within his head. For instance, one patient said: "I've heard enough. It goes right through my head." Another reported: "It's too close; it's horrible; I hear all the stuttering."

A second procedure is to produce a filtered record: that is, having a recording made of the cue communication with the emphasis first upon treble notes and then upon bass; or, again, with the emphasis upon a low volume or a high volume; or with spacing or repetition of key phrases; or with the introduction of an echo-back into the communication. All these variations serve to keep the patient continuously oriented toward each repetition and, hence, serve to diminish the most common defense—not listening.

On November 9, 1954, the first attempt was made, using an ordinary record to implant the following communication:

"I was afraid of them all the time. I mean I didn't dare . . . talk anything over with them whenever I went out on a date or something like that . . . I mean a lot of kids . . . you know . . . they'd come home and tell everything they did and everything . . . I never . . . I always felt as if I would be scolded, I mean if

I ever did mention what I had done and then I wouldn't do it."

At the end of 10 minutes, the patient, who had shown no response, said, "Is that a record, doctor?" Asked what she felt, she said: "I had no feeling at all as I listened; I was thinking of something else."

The same communication was then set up in filtered form. To this the patient's response was at once different. She commented that she felt extremely tired after listening to it, that the voice sounded as though it were inside her head; and she said: "It brought back a lot of memories of my childhood days." A few weeks later, when it was used again, the patient said: "When I listen to that voice now, I feel like screaming and putting on a tantrum. The voice seems to scream at me all the time. It is like the voice of a stranger, though I know it is my own. It seems to say, 'I was afraid of being scolded.' It says it over and over again. It makes me think that even with my husband and my father and my father-in-law I have to hide things from them. I feel trapped. I feel I can't talk to anyone."

Experience shows that the implant can most readily be set up if the driving is carried out during the last 10 minutes of the psychotherapeutic period, the reason for this apparently being that best results are obtained if nothing is done to interrupt the ongoing response of the patient to the fresh implant—as would be the case if one continued therapy afterward. It is sometimes useful, however, to spend some five minutes asking the patient what fresh recollections the implant has brought up. This immediately widens the area of the patient's response and probably tends to stabilize the implant.

A question which must be met at this juncture is: Why is it that statements which the patients have already made, had formulated in their own minds, and had listened to themselves uttering, should be so potentially disturbing when replayed to them—far more so than when they first made them, never more than a week before and sometimes only 10 minutes before. This question has been explored in some detail and reported earlier. Discussion will be limited to three brief statements: (1) The work involved in listening is far less than the work involved in speaking; hence the patient, when listening, is much freer to respond to what he hears. (2) The law of the summation of subliminal stimuli

seems to be operative: The longer one listens to a statement, the more response it evokes. (3) In all of us, a defense is set up against responding to all the implications of what we say. This defense appears to be with respect to a synthesis of air-conducted and tissue-conducted sound. The recorder, making use as it does of air-conducted sound only, evades this defense.

A. Findings Relative to Process of Setting up of Implant

Several factors governing the establishment of an implant have been identified:

1. *Intensity of Response.* The intensity of the response of the individual to the driving period tends to increase the dynamic character of the implant which is thus set up. This is true whether the response takes the form of tension, anxiety, hostility, unhappiness or any other facet of the intensification response. This statement must be qualified in that, as the area involved becomes progressively activated by the patient and worked through by him, the intensity of the response will, after having risen to its maximum intensity, gradually decline. Factors limiting the intensity of the response are: the patient's defense, his stress tolerance, and his capacity for desensitization. These will be discussed later.

2. *Amount and Repetition of Driving.* Repetition of the driving of the cue communication on subsequent days will reinforce the dynamic aspects of the implant. Less clear is what the optimum amount should be, either of the driving on any given day, or the frequency of the driving within a series of days. The practice has been to limit driving to 10 or 15 minutes on any given day, as it is found that thereafter the patient usually succeeds in establishing defenses or becomes so disturbed as to be unwilling to continue. The repetition of the driving thus far has been limited to a maximum of once a week and a minimum of about once a month.

3. *Defenses.* The defenses against the setting up of an implant are essentially the defenses against psychic driving itself.* The chief of these defenses are: (a) inhibitory reaction to implanting by thinking of other things; (b) suppression of emotional reaction to the material; (c) denial of responsibility for the statement,

*Cameron, D. Ewen: Ibid.

as where the patient states, "I listen to it as though it were a stranger talking"; and (d) misinterpretation; this is much less frequent, but on occasion patients succeed in completely reversing the sense of a statement, even when repeated 30 or 40 times, by changing it from an affirmative to a negation.

Methods of penetrating the defense which have been most successful are: (1) continued repetition; (2) the use of the earphones; and (3) the use of the filtered record, as indicated earlier in this paper. This last procedure, by its continuous shift in pitch, in volume, in spacing, and by other devices, penetrates the patient's defenses by repeated evoking of what Pavlov has termed in the animal the "orientation reflex." Other methods, such as psychic driving carried out during mild sodium amytal narcosis or during continuous sleep or during the induction phase of nitrous oxide, have not been nearly so successful. In practice, the penetration of defenses has not been found to be a serious problem.

4. *Stress Tolerence.* Knowledge concerning this is rather limited; but it would appear, from preliminary observations, that patients vary considerably in their ability to bear stress. Those who can tolerate stress well will, in general, show less tendency to react to psychic driving by the setting up of a lasting implant. On the other hand, those who tolerate stress very poorly are likely to respond, either by withdrawal from the driving situation altogether or by the setting up of powerful defenses.

5. *Capacity for Desensitization.* Concerning this phenomenon, there is still less information. But, from experience in other fields, it would appear that here, again, patients vary considerably in their ability to desensitize themselves; and those who cannot desensitize themselves readily will show a persistence of the implant for longer periods.

B. Findings Relative to the Effects of the Dynamic Implant

1. *Mobilization of Action Tendencies and Progressive Problem Identification.* The dynamic implant, especially when reinforced by repeated driving, tends to mobilize more and more of the components of the community of action tendencies from which it was taken. These components tend to appear in the patient's awareness. This fact, in turn, facilitates problem identification by the

patient and the therapist. This progress may be *assessed* in the following ways: (a) by the extent to which the patient thinks about the cue communication in the period between his treatments, and the extent to which his ruminating over the cue communication evokes new material; (b) by the new material which is evoked at the time of reinforcement of the implant—namely, by playing the material back again on a subsequent occasion; (c) possibly by general shifts in the behavior of the individual subsequent to implantation; for instance, it may be possible to demonstrate that the fact that the patient is now sleeping better is related to reorganization brought about by the implant; (d) dreams and psychological testing may also reveal the reorganizing force being exerted by the implant.

The first two methods of assessment are obviously the most direct and scientifically satisfying.

Illustrative of the progressive problem identification brought about by the dynamic implant, is the case of a girl who had come to therapy suffering from long-term feelings of inadequacy, marked dependency and a highly ambivalent attitude toward the male figure. The cue statement was:

". . . and there's . . . uh . . . there's still that tendency to idolize or despise . . . that tendency still exists . . . uh . . . I perhaps don't do either quite as strongly now . . . or feel either, I should say . . . But . . . uh . . . there still is that feeling, that one is a king and the other is a piece of dirt. Well . . . I mean . . . uh . . . as you very well know . . . you know exactly the type of fellow that I go for, and . . . uh . . . all others I just seem to have no use for."

Immediately after the first implanting, the patient stated: "I sound bitter and dissatisfied; I sound as though I am reaching for something I can't have." A change in behavior took place following this first implanting. After reinforcement, a further change took place, the patient saying that her boss whom she had hitherto found extremely attractive to her because of his ability and business drive was now no longer so; she did not think of him any more as being a tycoon, and a love affair with him terminated. A third period of driving brought about no change at the time; but a week afterward the implant had most considerable consequences: She gave up, she said, the whole idea of a "king"; she had now fallen in love with a man of her own age. Asked how

this came about, she said: "I simply made up my mind that since I can't get a 'king,' I would give myself a chance to like John. I don't put people on a pedestal like I used to; I don't feel the same way I used to about the boss. I used to have a bitter grudge against my father for my troubles; now I see him as a weak person I don't admire."

2. *Durability of Implant.* The writer's experience has shown that the implant, if not reinforced, declines in its activity fairly rapidly after two weeks; although, on occasion, it can be found operative as long as two or three months after the first implanting. As indicated earlier in this paper, the intensity of the implant can actually be progressively increased by a suitable reinforcement at rates of once a week to once a month.

3. *Shifting Attitudes Toward Cue Communication.* The writer has frequently encountered the interesting phenomenon of the according of negative values to the pattern of behavior represented in the cue communication: "I hate my whining voice"; or: "I don't have to please people all the time; I'm not like that any more." This imparting of negative values is particularly likely to occur either after repeated implanting or with the progress of psychotherapy in general. A working premise concerning it is that, since the patient comes more clearly to identify the neurotic components in the cue communication and to organize more efficient behavioral patterns, he tends to reject the neurotic patterns and to express negative feelings toward them.

4. *Mobilization of Action Tendencies.* An interesting question which arises is whether an implant can mobilize action tendencies laid down before the event embodied in the implant. Experience indicates that, while this does occur, it is much less usual than the mobilization of action tendencies laid down subsequent to the implant and derived from the basic situation outlined in the cue communication used in implanting.

Summary

1. By continued replaying of a cue communication, a persistent tendency to act in a way which can be predetermined in its general characteristics can be established. In other words, by driving a cue communication, one can, without exception, set up in the patient a persisting tendency for that cue statement, and other

components of the "community of action tendencies" from which it was drawn, to return to his awareness.

2. The dynamic implant thus established, and especially if reinforced by repeated driving, tends to activate more and more of the components of the relevant community of action tendencies. These components tend to appear in the patient's awareness.

3. This materially contributes to problem identification by the patient and the therapist, and, hence, facilitates the processes of therapeutic reorganization.

4. The dynamic qualities of the implant are functions of: (a) the amount and repetition of driving; (b) the intensity of the response; (c) defenses; (d) stress tolerance; (e) capacity for desensitization.

(5) The major continuing effects of the dynamic implant are: (a) progressive problem identification; (b) resulting reorganization of behavioral patterns; (c) negative evaluation of the neurotic patterns present in the cue communication used in driving.

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FETISHISM: A REVIEW AND A CASE STUDY

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Introductory

The meagerness of the literature basic to the prevailing psychoanalytic concepts of fetishism is noteworthy. The bulk of scientific writing on the subject, starting with Binet's pioneer study in 1887, consists of the work of the early and eminent sexologists, Krafft-Ebing, Ellis, Moll, Bloch, Hirschfeld, and others. This material is primarily descriptive in character. Freud based his first contribution to a theory of sex on the facts gathered by these workers; and other analysts, even the prolific Stekel, borrowed case material from these writers.

Analytic case studies of fetishism are not plentiful. Clinical documentation of the basic analytic theses on the subject is surprisingly scarce and fragmentary. Several analysts have specifically commented on the scarcity of this material, noting that fetishism "does not often come under the scrutiny of analysis."[1] In addition, as Freud stated and others have confirmed, fetishistic practices rarely are the presenting symptoms, the fetish making "its appearance in analysis as a subsidiary finding."[2]

Therefore, the opportunity for the analytic study of a case of fetishism with numerous classical features, in which in addition, the fetishistic problem was one of the presenting complaints, seems to warrant its presentation. The plan is: first, to review critically the analytic literature on the subject; second, to add this case study of a homosexual foot-fetishist; and finally, to suggest tentatively some other formulations on the problem. These, briefly, are the aims of this paper.

Review of the Literature

The term "fetish" was brought into general use in 1760 by a French anthropologist, Charles de Brosses, in his study of the cults of fetish gods. Fetishism may be defined in a general way as the "worshipping, adoring or loving something that serves as a substitute for the original object."[3] In normal sexual life there usually exists a more or less pronounced preference for a particular portion of the body of the opposite sex. For the fetishist,

however, this preference may not be limited to a part of the body, but may extend to inanimate objects, which are most frequently articles of female wearing apparel, since fetishism is extremely rare in women. The fetish constitutes the non-genital precondition for sexual gratification, which is preponderantly if not exclusively masturbatory in character. Foot and shoe fetishes are most frequently reported.

The first scientific study of this most peculiar and puzzling phenomenon of sexual psychopathology was published by the eminent French experimental psychologist, Alfred Binet, in 1887.[4] He propounded a theory in terms of the prevailing associationist psychology of the period, and it partook of the mechanistic nature of that doctrine. Causal significance was assigned to a merely fortuitous circumstance, supposedly in a setting of predisposing constitutionality. Binet's theory accepted by the major sexologists of the day, was succinctly stated by Krafft-Ebing in the formulation "that in the life of every fetishist there may be assumed to have been some event which determined the association of lustful feeling with the single impression. This event must be sought for in the time of early youth, and, as a rule, occurs in connection with the first awakening of the vita sexualis. This first awakening is associated with some partial impression (since it is always a thing standing in some relation to woman), and stamps it for life as the principal object of sexual interest. The circumstances under which the association arises are usually forgotten; the result of the association alone is retained. The general predisposition to psychopathic states and the sexual hyperesthesia of such individual are all that is original here."[5] This was essentially the pre-Freudian scientific thinking on fetishism.

The basic Freudian concept of fetishism was established in a remarkably few papers by Freud and Abraham, in which clinical material is cited in a fragmentary manner. In the first of the *Three Contributions to the Theory of Sexuality*,[6] Freud discussed fetishism as a deviation of the sexual instinct in regard both to aim and object, and accepted Binet's assertion as to the influence of an early sexual impression in the supplanting of the love object by a fetish. He said that "this substitute is not unjustly compared with the fetish in which the savage sees the embodiment of his god." He too postulated a constitutional pre-

disposition in the form of an "executive weakness of the sexual apparatus." The formulation added little if anything to Binet's ideas on the subject. It was mechanistic in form and instinctivistic in content.

In 1909 Freud read an unpublished paper on the "Genesis of Fetishism" before the Vienna Society.[7] However, in his psychosexual study of Leonardo da Vinci published in 1910 Freud stated the nuclear propositions of what was to be his definitive stand on the problem of fetishism. This has prevailed relatively unaltered in orthodox psychoanalytic doctrine.[8] The salient early formulations were: The male child in his overvaluation of his penis concludes that even women have this prized organ. When forced by the results of the scopophilic partial impulse to deny this, he concludes women have had this organ cut off. "But the fixation on the once so vividly desired object, the penis of the woman, leaves ineradicable traces in the psychic life of the child, which has gone through that fragment of infantile sexual investigation with particular thoroughness. The fetish-like reverence for the feminine foot and shoe seems to take the foot only as a substitutive symbol for the once revered and since then missed member of the woman." In a word, this is the infantile assumption of the existence of the phallic mother, as a result of the child's intense desire to see her genital, which he can only believe to be a penis.

Also in 1910, Abraham published a paper which is important in the development of the classical position on fetishism.[9] Proceeding on the basis of the vicissitudes of the partial impulses or instincts, Abraham confirmed Freud's privately expressed hint that the selection of the fetish depends on a repressed coprophilic desire to smell. As a result of the renunciation of this originally strong pleasure in disgusting body odors, the feet and hair become fetishes. In fact it is the abnormal strength of several component impulses (looking, smelling, sadomasochism) and their partial repression and displacement that account for the formation of fetishes.

In this paper Abraham made an important observation which the study of the literature and the case presented here amply confirm—there is an extraordinary reduction in the fetishist's sexual activity. He said of his case that "in practice he had never

moved outside the field of auto-eroticism." Stekel commented that masturbation is practically the sole sexual activity of the fetishist. "There is no fetishism without masturbation."[10]

In 1914, Freud read another unpublished paper before the Vienna Society on "A Case of Foot Fetishism." The patient, 47, had always been impotent. Ernest Jones states that Freud assumed a primary excess of erotogenicity in the foot in such cases. "The most important factor in the case Freud saw in the patient's masochistic attitude, which had been largely brought about as a reaction to intimidation," i.e., a threat of castration by the father when the patient was a child, and the shock of being surprised as he attempted coitus with a girl at puberty.[11]

Finally, in 1927 Freud summed up his position on fetishism in a paper of that name.[12] He stated that the "fetish is a substitute for the woman's (mother's) phallus which the little boy once believed in and does not wish to forego... for if a woman is castrated then his own penis is in danger." "The fetish is a token of triumph over the threat of castration... [and] it also saves the fetishist from being a homosexual by endowing women with the attribute which makes them acceptable as sexual objects." Freud is forced to confess that it is not understood why the sight of the penisless female results in homosexuality in some, in fetishism in others (in homosexual fetishism in the present writer's case), and why, in the great majority of persons, it is overcome. The fetish may mean also that "what is possibly the last impression received before the uncanny traumatic one is preserved as a fetish." Moreover, he added, it is not always possible to discover the determination of a fetish. Finally, "the normal prototype of all fetishes is the penis of the man, just as the normal prototype of an organ felt to be inferior is the real little penis of the woman, the clitoris."

Up to this point there has been no reference to ego or personality structure. Fetishism is simply one of the solutions of the universal castration complex, and "the fetish a token of triumph over the threat of castration." Freud reverted to this theme in an unfinished fragment, "Splitting of the Ego in the Defensive Process."[13] In this paper, he cited the formation of the fetish in response to the castration threat as an example of a neurotic splitting of the ego. The conflict between the demand of the in-

stinct (to masturbate) and the command of reality (castration threat) leads to two contrary reactions. The child rejects the prohibition by denying reality in his creation of the fetish as a substitute for the penis which he missed in the woman. He does not, like the psychotic, hallucinate the missing penis. He merely displaces the importance of that prized organ onto another part of the body of the woman. The price for this saving maneuver, Freud said, is a permanent "rift in the ego," which increases in time.

In his last work of any considerable length, "An Outline of Psychoanalysis" (1938), Freud repeated this conception practically unaltered.[14] "The fetish was created with the intention of destroying the evidence for the possibility of castration, so that the fear of castration could be avoided." And, "denials of this kind often occur, and not only with fetishists." They are "incomplete attempts at detachment from reality." These final formulations by Freud reveal no real consideration of individual personality development, certainly not of social and cultural influences on such a growth. All is biology and accident. To borrow his words, "life's determinants" remain the "fatalities of our constitution" and the "accidents of our childhood."[15] He reveals his mechanistic nineteenth century materialist philosophic orientation in assuming in his concept of fetishism that all important psychic phenomena must have a physical underlying process. Biology is destiny. He did not conceive of any behavior unrelated to physiological processes, but rather related to total human personality and consciousness, the latter deriving not from physiology but "from human practice of life as it results from the conditions of human existence."[16] It will be the author's contention that fetishism is not determined by biology and accident, but arises out of life conditions that result in the evolution of the total human personality as an adaptational system with its distinct and individual life pattern.

But to continue the review of the literature, what has been the fate of this early, yet definite, analytic formulation in fetishism?

James Glover in 1927 published a case of shoe fetishism in which he claimed to have found all the elements postulated by the current theory.[17] The interest in the shoe merely concealed

the interest in the foot as a penis substitute. The subject's shoe-fetishism and associated sadomasochistic activity related to his "intense castration fear and guilt . . . and his incestuous scoptophilic and sadistic impulses . . ." He noted that his patient had used alcohol to suppress the conscious wish to be a woman. As regards the smelling component, he declared that shoes represented feces, as malodorous objects detached from the body. Glover in no way modified the existing formulation on the problem.

In 1930 Lorand presented, in fragmentary form, observations on a boy of four, as further evidence of Freud's conception of fetishism.[18] This child kissed and stroked the shoes of his mother's women friends whom he liked. He also lifted their dresses, asking each if she had a penis as large as his father's. He dressed paper dolls for hours, and took an intense interest in his mother's clothes (as did the patient reported in the present paper). He slept in his mother's room and was intensely jealous of the father. He had strong scopophilic impulses and, when he drew boys and girls, he drew them both with penes. And, of course, Lorand concluded that the "fetish is a substitute for the woman's penis," and that the "woman can be no one else but the mother, who is the first love object."

Also in 1930, Fenichel published a paper on the psychology of transvestism, which is pertinent to our subject.[19] He stated that "we now know that all perversions, including transvestism, are intimately connected with the castration complex . . ." It is the dread of castration that conditions the disappearance of infantile sexuality and the passing of the Oedipus complex. The homosexual has no regard for a person without a penis, the fetishist denies the existence of penisless people, and the transvestist along with the exhibitionist and scopophiliac incessantly seek to refute this fact, all seeking to master their anxiety by denying its cause, namely, dread of castration. In brief the fetishist believes in the phallic woman, the passive homosexual identifies with her, while the transvestite does both. Be this as it may, Fenichel added nothing fundamentally to Freud's basic conception of fetishism.

Balint, in a paper in 1935, attributed further symbolic significance to the fetish.[20] Since the vast preponderance of fetishists are men, and one usually puts on the fetish or puts part of the

body into the fetish, it, therefore, appears that the fetish represents the vagina and the womb. The few cases of female fetishists that Balint knew of were "masculine" and performed in relation to their fetishes in the same manner that men did; i.e., one put her nose into the handkerchief used as a fetish.

Further, Balint insisted that the fetish, which had to have an odor, symbolized the feces, and these, of course, were especially the feces of the mother, which together with the bodily contents generally, are the sexual aim of the child, as Melanie Klein is purported to have demonstrated. And, finally, kleptomania and transvestism, according to this contribution, rest on the same psychological basis. In kleptomania, the subject seizes the maternal contents, while in transvestism—by donning, or hiding within, the female dress—the transvestite gains the maternal contents. The substantiation of these conclusions is clinically quite tenuous.

Kronengold and Sterba reported on two cases of fetishism in 1936.[21] In both there is said to have been identification with the woman who suffers masochistically in intercourse but keeps her penis—represented by a rope fetish in one case and a rubber sheet fetish in the other. In both cases, the fetishism is the result once more of the need to deny the existence of penisless woman. The rubber-apron fetish is traced to the patient's purely chance observation at the age of four of the diapering of a female infant lying on a rubber protective sheet. The authors of this paper reaffirmed Fenichel's formulation on transvestism and wished to extend it to the masochistic fetishist, for whom the woman's clothing carries a phallic significance as a fetish.

Up to this time little or nothing had been written about personality and fetishism. In his "Observations on the Ego Development of the Fetishist," published in 1939, Payne, after reviewing the concept developed by Freud and Abraham, suggested, for the first time analytically, the role of personality development in the production of fetishism.[22] He felt that the fetish is related to ego defense mechanisms and ego development. And whereas the classic idea of the function of the fetish was the denial of the absence of the penis in the female, Payne stated that its function is defense against an archaic wish to destroy the love object. This is the defense against an anxiety situation by its internali-

zation (introjection) as postulated by Melanie Klein. Payne believed that the fetish is a defense against a real sexual perversion, namely, what would result from the sadistic-component impulse uncontrolled. The fetishist, he felt, has more anxiety and guilt than the true pervert, and thus resembles the neurotic. The fetish serves to reassure that the sadistic impulses have not destroyed the love object.

Yet, in the final analysis Payne too found that the psychology of the fetishist is "dominated by castration fear," fear connected with infantile aggressive impulses bound up with sexuality. So although Payne correctly said that a real comprehension of the causes of this sexual anomaly (fetishism) can only be obtained by considering the fetish in relation to the individual's whole psychical development and by taking into account the other morbid symptoms which are invariably present," it is apparent that he still considered the problem of character development to be one of the vicissitudes of the component partial instinctual impulses. It is still a matter of the mechanistic-biological rather than the dynamic-cultural orientation in the matter of personality development. Nonetheless, Payne did describe the fetishist personality as manifesting depressions, paranoid fears, severe inhibitions and self-destructive tendencies.

A contribution in 1940 by W. H. Gillespie stressed the lack of specificity in the etiological role assigned to the unbiquitous castration anxiety, which results both in homosexuality and in fetishism, and, most frequently, in naught at all.[23] He felt this was a problem that analytic theory had to face. Still he went on to attribute fetishism to castration anxiety produced by a strong admixture of anal and oral trends. He felt the oral and anal features were merely a cover for the deeper phallic anxieties, for, if it were otherwise, how could one account for the fact that fetishism was almost exclusively a male condition. He was also hard-pressed to explain the homosexual elements in his case (and in many other cases such as the one in the present paper), since Freud had said that the fetishist was saved from homosexuality by his fetish.

A case reported in his book by Dalbiez in 1941[24] stressed the sadomasochistic elements in fetishism. He reiterated the earliest etiological formulation, based on the conception of a constitutional

factor (undifferentiated sexual impulse) directed toward and finally fixated upon an anomalous sexual aim by an external psychogenic factor. This is very general and there is complete absence of any recognition of the specific nature of personality development.

In an unusual case of fetishism reported by Bergman in 1947 there is the first reference to the fact that the nature of a person's real relations to his parents and to other persons may be of significance in the psychogenesis of fetishism.[25] The patient was a youth "at the threshold of manhood," who had a fetishistic fascination for automobile exhaust pipes that were perfectly shaped and emitting softly blowing gases. He rarely touched the exhaust; but when he did, he would insert his finger or handkerchief. Like fetishists in general, he would masturbate subsequently. As a child he would torture animals with incredibly cruel methods. He struggled against his fetishistic impulse, which began at 13. During such periods of struggle, he felt helpless and would burst forth with serious antisocial behavior such as arson. The patient had a brutally dominating father and a shadow-like passive mother. Significantly, the author remarks that "an attachment to a machine can only grow over the ruins of completely shattered relationships with human beings." David Rapaport, who tested a number of fetishists psychologically, reported that all of them showed borderline psychotic conditions. In such cases, one could assume that the fetishism grew out of, and was a defense against, a psychotic personality structure. Certainly, Bergman's case raises the notion of fetishism as the result of profound disturbances in interpersonal processes.

Romm, in 1949, published the case of a hair-cutting fetishist, who not only cut his wife's hair as a condition for sexual fulfillment, but also at one point cut off all his own hair; on head and body.[26] (From the clinical standpoint, this raises the question as to the possibile schizophrenic process present in this case, and brings to mind Rapaport's report, just cited.) Romm maintained that "like the homosexual, the fetishist is attempting to escape from women; when he cannot, he compromises by depreciating them... The fear of the sexual partner plays a cardinal role at all times." The fetishist is free from rivalry with his sex and for the most part may be free from dependence on another

person for sexual fulfillment. The points raised in this connection by Romm impinge on the suggestion to be made, namely, that the fetishist does not suffer from fear of being castrated, but rather from the feeling that, in a sense he has already been castrated, and is inadequate to assume the role of the male in life generally. Significantly, in Romm's case, the author felt that the patient's cutting of his own hair represented, for him, his castrated state.

Romm made several other observations pertinent to the thesis to be expounded. She stated that most fetishists are passive. And she suggested that their method of adaptation is to symbolize and substitute rather than to carry out the underlying desires. This is a most significant remark, emphasizing the extraordinary utilization of fantasy in the adjustment of the fetishist, and perhaps indicating the basis for Rapaport's borderline-psychosis findings.

The last three analytic studies to be considered were published in 1953. First, Peabody, Rowe, and Wall wrote on the relationship of fetishism and transvestism, noting that they were apparently closely allied.[27] In both, there is characteristically an overvaluation of woman's clothing, as in the case to be presented. The transvestite is said frequently to have conscious strivings to become a woman, albeit the phallic woman. It is of note that in the very rare cases of fetishism in women, the fetish is said to represent the penis the woman desires, out of identification with the father, and that it is also a defense against the emotions associated with ideas of penis lack. The female transvestite is the result of penis envy, with a greater element of "playing father." In any event, the driving force behind both male and female fetishism is the castration complex. Anatomy remains destiny.

Second, Phyllis Greenacre contributed an elaborate paper on the possible relationships between fetishism and a faulty development of the body image.[28] Despite the detailed and complex presentation, the clinical value of this paper is diminished, since the author regretted the impossibility of presenting detailed case histories. It appears that the pre-fetishist early in his history develops "an insecure and unstable body image" because of, (1) severe or continuous disturbances in child-mother relationships with increase in separation anxiety resulting in increased touch-

ing, feeling and seeing needs; (2) occurrences resulting in subjective feelings of fluctuation of total body size, (i.e., in emaciation, weight gain or edema; in fevers, anesthesia, etc.; in activities such as massage, violent tossing, etc.); (3) the persistence of an unusual degree of primary identification (i.e., increased introjective-projective mechanism). In a number of her patients, Greenacre felt a significant factor to be early very close visual contact with a female, mother or sister, relatively close in age. There is in such cases a primary identification, such as is seen in twins, with a "well forecast bisexual splitting of the body image even antecedent to the phallic phase." At this point, the author regretted inability to present detailed case histories. Thus the import of the material is difficult to assay. In any event the disturbances occur in the first period of life, the first 18 months or so.

From the second to fourth year there is another period of disturbances. There is, according to Greenacre, the continuation of mother-child dysequilibrium and, in addition, usually severe, castrating incidents of real trauma, such as witnessing a "mutilating" occurrence or operation, like a birth in the home or one's own tonsillectomy. This actual castration threat, seen or verbalized, plus the more pleasurable sensations of the phallic phase "inevitably" arouse severe castration anxiety; and the threat "reinstates the primitive disintegrative anxiety of the first era [up to 18 months] because of the strong body-phallus equation... so that the phallic period which should be the time for consolidation of the genital part of the body image instead becomes a period of increased anxiety and uncertainty regarding the genital parts," leading to bisexuality and a corresponding ego split. Such children, destined to be fetishists, hardly solve their Oedipal problem, and with pre-puberty or adolescence, fetishism plays its dramatic part in the compulsive attempts at control of the Oedipal conflict. In brief, fetishism results from disturbances of pregenitality, and the fetish being tangible, visible, not readily destroyed and unchanging in size, reaffirms the genital integrity of the fetishist. The fetish, created to deny the penisless woman, functions also "by reinstating through visual, olfactory and actual introjection, the phallus of the individual." Once again the clinical

observations are unfortunately omitted, and the reader is left with a speculative formulation.

Finally, there is Bak's paper on fetishism.[29] He stressed the weakness in the ego structure, inherent or secondary to physiological dysfunctions or disturbances in mother-child relationship threatening survival. There was simultaneous and alternating identification with the phallic and the penisless mother, corresponding to Freud's postulated "split of the ego." The "separation from the mother is experienced as an equal, if not greater, danger than loss of the penis." Both the danger of castration and that of separation are defended against by the fetish. The triad of fetishism, homosexuality and transvestism results from compromises of the different phases of identification with the mother. Bak felt that the wish to identify with the mother intensifies the castration anxiety, since, as Freud taught, it is the fear of castration that causes the boy to give up his attachment to the mother. One senses that in these formulations, separation from the mother is conceived in biological, not social, terms—not in terms of individuation, growth and social role assumption.

To summarize this extended, yet highly condensed, survey it is evident that the original formulations on the problem by Freud and Abraham have persisted fundamentally unchanged through the decades, for present-day analytic thinking is still mechanistic-instinctivistic in its traditional manner. Fetishism is still a defense against castration anxiety by denial of the penis-less mother, which leads, mechanically, to a splitting of the ego. There has been scant attention to personality formation and structure, and a schematic approach to mother-child relationships. True, Rado, who no longer accepts libido theory, has considered sexual behavior from a biosocial point of view, stating "that the male-female sexual pattern is not only anatomically outlined but, through the marital order, is also culturally ingrained and perpetuated in every individual since early childhood."[30] (For Rado, fetishism is a reparative process, in which a deficient male-female pair is utilized for sexual gratification.) But generally the literature on fetishism fails to reflect the understanding that instinct is no longer paramount in human activity, and that "society and parents condition the infant, supply his motivations, and promote his long-drawn training at the difficult task of becoming a normal

human being," an individual with specific roles in a definite kind of society and culture.[31]

Case Report

A 22-year-old man presented himself for help because of depression, feelings of inadequacy and fear of "homosexual tendencies." Since early childhood, he had been aware of his sexual interest in men's feet, but until he had read about this aberration in a college textbook on abnormal psychology he had not suspected that such a "tendency" existed in others. He had never revealed his anomalous feelings to anyone else.

He was slight, extremely soft-spoken, gentle in manner and definitely somewhat effeminate in movement. He was always well-dressed and well-groomed. He was overpolite, bordering on the obsequious and servile, attempting to comply in every way. He generally appeared somewhat depressed. The history that follows was obtained in the course of analytic work.

At the age of six, the patient was at a beach resort hotel with his parents. One day, while he and a girl of the same age were awaiting a little companion in her room, the girl's father entered. Apparently tired, he sat on the bed and proceeded to take his shoes and stockings off, expressing great relief as he did so, and remarking that his feet hurt. The little girl called the patient's attention to the man's naked feet, which were not "pretty at all." The patient recalled: "I looked at the feet more closely. They looked tired, the veins sticking out. I became excited and I think that I had an erection." He and his friend soon left the room, and the incident ended at this point.

At about the same time in his life, he recalled, he enjoyed the opportunity of playing with his maternal grandfather's feet, an activity he found exciting. His grandfather was a gentle and kindly person, solicitous of his grandson. Because of "rheumatism" in his feet he would frequently bathe them to relieve the pain. "I once asked him to show me his feet. He took off his socks and showed them to me. I thought they were nice and white. His feet are the earliest feet I can recall handling." Later the bathing of tired feet was to become a frequent masturbatory fantasy for the patient.

After these episodes, he was excited whenever he saw the naked male foot, and for a short and indefinite period, the naked female

foot was also stimulating. The actual sight or fantasy was of no effect unless the foot was "tired"—"distinctly so with the veins more prominent." He recalled that early in the development of his trend, he frequently saw his governess walk about barefoot. She had "ugly feet with corns and calluses. Their ugliness bothered me and I wanted her to wear her shoes." He thus became aware of another requirement of his fetish: that the foot must be free from corns and calluses and other disfigurements. And, as he remarked, men have nicer feet, more frequently free of such blemishes, which are caused in women by their unsuitable shoes.

He recalled several incidents of significance from the ages of nine to 11. One rainy day he was playing with his girlfriend in her apartment. Her father came home and removed his wet shoes and socks. The patient was excited by the sight and persuaded his friend to touch her father's feet, since he could not do so. It was an act by proxy that was to be characteristic of his behavior. He recalled that he was greatly excited, playing with this girl's feet during this period of his life. At about 11 he demonstrated to his school mates that he could produce an erection by looking at their naked feet. The entire foot was stimulating, no particular part being more exciting than the rest.

A very significant episode in the evolution of the fetish occurred in his twelfth year. He had accompanied his parents on a vacation, together with his father's cousin. Each day he followed his father and cousin on the golf course. One day, this cousin waded into a pool to recover a ball, and then asked the patient's aid in removing his wet shoes and stockings. "I had previously fantasied doing this for him when he would come in from long walks and take off his shoes, complaining of tired feet. Now that I was actually doing it, I was very excited. That night I masturbated for the first time, and it was with the image of a man's naked foot that was painful and that I was rubbing and massaging. The next day, walking on the golf course with my father and cousin, I had numerous erections, fantasying that I was a chiropodist with numerous men coming to me with their sore feet."

The requirements of his fetish were crystallizing. The foot, observed or imagined, must be one in pain, having just been released from a tight and uncomfortable shoe. The patient is rub-

bing the foot and the man is expressing relief at having his foot massaged. "It is the expression of relief that is of prime importance, the relief in response to my rubbing the foot," the patient said. Implicit, is the man's gratitude for relief. Therefore, the ordinary foot is not stimulating. In his fantasy, the chief form of fetishistic activity, the patient elaborates details as to why the shoes hurt, just how the man removes them, and precisely how the man expresses his relief. The mere idea of an expression of relief has a stimulating effect on him. The important aspect of the relief from pain is that it is the result of the patient's ministrations to the foot. "The sole purpose in the elaborate fantasy is the relief of the man's pain." The patient has noted mild excitement accompanying the idea of the relief a man might express in urinating or defecating.

The foot in fantasy or reality must be clean and odorless. The notion of sweaty, malodorous feet would ruin the fantasy. The preferred foot is a "masculine" one, the foot of a grown man, not that of a boy. If a man were effeminate, his foot would be of no interest. His fantasies concern men he knows of, whom he has recently seen either in person or in a photograph, or on television, or in the movies. When he saw a man on television bathing his tired feet, he immediately had an erection. The size of the foot is important, the larger foot being preferred. The general appearance of the man is of some significance in influencing his selection for the fantasy. The patient prefers handsome men, although there are exceptions. The color of the foot and the amount of hair on it are without any determining value.

The shoes or stocking of the man are of no interest and have no stimulatory value. Only the naked foot in pain has the high excitement value for the patient. He has no feeling about his own feet. He never sucked his toes in childhood, an activity noted in the history of some foot fetishists. At times, when he is aware of his own relief in removing a tight shoe, he is stimulated to the masturbatory fantasy of some other man having such relief.

In some of his fantasies, the imagined foot reveals red markings from the pressure of the socks. In discussing this, the patient recalled the fact that on the vacation at 12 during which he had begun to masturbate, he had observed the underwear impressions around his father's waistline and was stimulated to

erection and masturbation. On the few occasions that he placed a woman in his masturbatory fantasies, he imagined her taking off her tight girdle, revealing the deep impressions on her body, and expressing great relief at the release. Although since the age of 12, he has frequently used his father's foot in masturbatory fantasy, in reality he dislikes his parents' feet. He often teased them to the effect that their ugly feet had caused him to dislike all feet. He often said: "I think the foot is the ugliest part of the human body." He does not like to hear his mother complain that her feet hurt. "Her toes are extremely large and she had been repeatedly teased about it. I would not touch her feet. She once asked me to massage her feet and I refused. Nor would I touch my father's feet." Actually, his parents' feet have always had a disgusting quality to him.

Several times during boyhood, while on hikes, he had the opportunity of massaging a male friend's feet. This would be very exciting and would later furnish the material for a masturbatory fantasy. These episodes never led to frank masturbatory activity since he was unwilling to reveal the significance of the massaging to the friend. He had had a male friend in recent years who had seemed to share his interest in the foot; but although they discussed this at great length and often, and although this gave rise to rich fantasy activity, it did not lead to overt fetishistic behavior between them. Masturbation remained the patient's sole sexual activity. He has frequently attempted to masturbate with a woman's foot in his fantasy, but this would only end up with the substitution of the specifically stimulating man's foot. As he stated: "I enjoy it more. If I had my choice of the penis or the foot, I would select the foot to caress, a foot in pain to be soothed and relieved by my rubbing and caressing." He has never masturbated before a mirror, a characteristic attributed to fetishists by Stekel. He has no interest in stroking such things as furs or silks. He has no masochistic fantasies, such as of being trodden upon.

The patient is an only child, born prematurely. He was an unhealthy child from the very outset. He ate poorly, vomited a great deal, and was constantly constipated, requiring cathartics and enemas, which he hated. He had numerous allergic manifestations, and at an early age required a "sinus operation," which

was disturbing. At 10 he had a tonsillectomy. Because of his ill health he was too difficult for his mother to handle. He was cared for by a governess or a maid until he was 10, and he attended private schools.

The patient's father is a big man physically, weighing more than 200 pounds and being more than six feet tall. He is an extremely successful salesman-executive, popular, and "liked by all." He is extremely well dressed and spares no expense for his personal needs, although he tends to be stingy with his wife and son. He is "hot-tempered, nasty, sarcastic, and intimidating, and basically selfish." The patient has always been afraid of his constant belittling. He is completely intolerant of any contradiction by his son, his attitude being, "Who are you to tell me anything?" He wants his wife and son to be dependent upon him, and is angered if his wife suggests that she work because of boredom.

He is a fanatical sports enthusiast, and has always been obviously disgusted with the patient's lack of interest, and lack of ability, in this field. He would take his son to baseball games religiously, hoping to get him to share his own enthusiasm, only to be bitterly disappointed by the patient's boredom. In disgust and bitterness, his father would "make fun of him," and the patient can still hear his father calling him stupid. His father, even at present, frequently greets him with some such salutation as "Dopey." In his presence, the patient always is painfully self-conscious, and the two can sit together for hours without exchanging a single word.

The patient said: "We have so little in common. I often wonder about his attitude toward me. I resented his fanatic interest in sports, which obviously came before me and mother and everything else. Yet I felt bad for him one day, when he said bitterly that he had never believed that a son of his would not like athletics. Obviously I am not the son he wanted. My attitude toward athletics was a bitter disappointment to him. Although I was more at ease with him as a child, I always feared him and wanted his approval. He is the very opposite of me, a real man's man, a real athlete with a great interest in the sports world. When I tried athletic activity, I was a terrible failure at it." The patient recalled that even when he got good grades in school,

he refrained from telling his father, feeling that they could not possibly alter his father's opinion of him. "I would like him to be proud of me, but I have done nothing to make him proud."

The patient's mother is a petite and very attractive woman, of whom the patient was always very proud, even of her popularity with men. She is jolly, flirtatious, and extremely preoccupied with her interest in clothes. Like her husband she is high-tempered. She administered all the physical punishment the patient received in his childhood. He recalls that she would even kick him in her anger. There was a period during early childhood when he was "bratty, quick-to-temper, and self-willed," so much so that he could not get along with other children. In time he became quieter, and unable to express anger. "I rarely lose my temper, only get mad inside."

His father's occupation made it necessary for him to be away from home for six to eight weeks, three or four times a year. As the patient stated: "I was always with my mother, or with my governess or a maid up to 11, or with an aunt who lived with us for a time. Mother and I were very affectionate with each other, which at times seemed to annoy my father. I would tell her everything, rarely talking to my father." But, she constantly ordered and directed the boy, telling him when to eat, clean his teeth, have his hair cut, or go to the doctor. She treated him like an infant, even using baby talk with him right up to his majority. Friends would constantly admonish her to allow her son to do as he liked, but she continued her oversolicitous, dominating behavior. And the patient submitted.

His parents always quarrelled bitterly, apparently being as incompatible as he always felt himself to be with his father. He recalled that, even as early as four, he felt sorry for his mother, who would come to sleep in his room after quarrels. He slept in the same room as his governess or the maid. When he was about seven, he became aware that his mother was secretly seeing another man. On a few occasions, he even met the man. But usually his mother would send him to spend a week-end with relatives while his father was out of town, or else leave him with his father when the father was at home. It bothered the boy that his mother thought she was fooling him. But mainly he felt lonesome and missed her when he was left with the father or relatives.

It made him very angry, knowing where his mother had gone. He condemned her for her actions, feeling that at least his father did not cheat. This liaison of the mother lasted many years. During this period, he developed a fear that his mother would die, an expression of his hostility at her abandonment of him, and also a fear of his own death out of guilt. Both fears disappeared when his mother and her lover separated.

He always had difficulty making friends, as in school. He generally sought the company of girls or women, feeling inadequate with the male sex. As he said: "As a child whenever I made a friend, it was a girl." From early childhood to the age of 11, he idolized a girl of his own age, who was a very good athlete. But he did not engage in athletic games with her; instead he played dolls with her. Except for this girl, he never played much with other children. His governess had the habit of taking him to secluded areas in the park where he would play alone. This lonely play encouraged his "vivid imagination." He recalls that in his loneliness he talked to himself a great deal. His mother and governess would scold him for this. In addition to playing with dolls with his girlfriend, he enjoyed cutting paper dolls up to the age of 12. He gave up this activity only when he was embarrassed by a neighbor's discovering him at the pastime.

He lived largely in a world of fantasy. He was an avid visitor to the movies. He was constantly daydreaming "about things that couldn't possibly be." From early days he was enamored of the theater, spectacles, displays, pageantry. He said: "I would often walk and talk to myself and dream. And this has been so ever since I can recall. I would even set aside a time in the evenings when I would be free to daydream at length. For example, I would elaborately picture my maiden aunt having fun and being married, doing all the things she never did." He once had a continuous fantasy over several months about having a sister. He pictured the events in great detail from the time of her birth, through her growth, schooling and finally marriage. Marriage always played a big part in his fantasies, and still does. He thinks of the girl he is to marry, and plans the wedding down to the last detail from the invitations to the honeymoon, from the minutest detail of the bride's dress to the music to be played. As a child he had an intense interest in weddings. He loved to hear

all about his parents' wedding in great detail. He would wait outside weddings to catch a glimpse of the bride.

As a boy he was a "camera bug," taking and looking at pictures incessantly. He was willing to look at anyone's pictures. He looked endlessly at the albums of other people. Anything relating to photographs of people interested him. He had a special interest in photographs of his mother that had been taken at any time before his birth. His interest began early. As a young child he liked being photographed.

For many years he has been self-conscious and unhappy about his feminine mannerisms and interest and his lack of masculine skills, especially in athletics. He cannot swim. He never attended summer camps like the other boys of his socio-economic group. In elementary school, he was chided for his sing-song "girlish" voice, so that he eagerly welcomed his deeper voice at puberty. He was told that he threw a ball like a girl, and was even called "fairy" by the other boys. In high school, he was teased for sitting like a girl with his legs crossed. In his self-consciousness, he would never admit liking children because he felt such an interest was not masculine.

He has always been uncomfortable about his interest in feminine things. He would discuss his mother's clothes with her constantly. Even as a young boy, women's clothing interested him intensely. He would draw pictures endlessly of women's clothes. He always had good ideas on the subject, would tell his mother what she should wear, and still does. He spent a lot of time with his mother. He enjoyed going places with her. "We are more like mother and daughter than like mother and son." His mother was aware of this, even when he was a young boy, told him that he acted too much like a girl, and urged him to have more boy friends.

He carefully refrained from showing his father this interest in women's clothing and would make no suggestions to his mother while his father was there, realizing his father would be aghast. As a young child he was fond of putting on his mother's clothes, not including her underclothing. He would parade around in them, surveying himself in the mirror. He equally enjoyed watching his girlfriend dressed in her mother's clothing. He would recall for days, in the minutest detail, the dresses worn by the actresses in the movies he saw endlessly. At about 11, his transvestite be-

havior came to an abrupt end, when his father unexpectedly came upon him engaged in this activity. His father was obviously very much disturbed and said so in no uncertain terms. The patient very solemnly promised never to do it again, and never did. He determined to be all boy. "I tried, but I could not play a game as simple as tossing a ball at a penny on a sidewalk crack. Mother, after watching me at such a game with my father, said: 'Father and I are disgusted with you.' I felt horrible."

He had had little or no instruction in sexual matters at home. As a child, he was constantly exposed to the sight of girls and women undressing, girlfriends, aunt, mother, and the domestic workers with whom he shared bedrooms. He frequently saw his mother naked, because "she was careless and indifferent." He vividly recalled one incident at four or five. He looked up at his mother's genitalia as he stood before her while she was dressing. She slapped him sharply, despite the fact that she had always exposed herself freely to him and continued to do so after this incident. In discussing this episode, the patient said: "I feel and have felt that mother has no respect for me as a man, since she carelessly exposes herself to me even at this late date. It infuriates me, and I have frequently told her so." He recalled that as a young child he showed his mother that he had an erection. She was amused and laughingly pointed it out to his aunt, who touched it in jest.

As a child, he took showers with his father; but, later, his father rarely undressed openly before him. Up to the age of 10, he would get into his parents' bed on Sunday mornings, when he enjoyed immensely tumbling about with his father.

At the time he began masturbating, he had an allergic dermatitis of the scrotum and the inner surfaces of his thighs. Because of her attention to this condition, his mother became aware of his masturbation. She warned him that it was unhealthy and that such activity could cause one to become sluggish mentally, even "imbecilic." At this time, he was masturbating several times daily and this "information" caused him much anguish and fear. His father also warned him somewhat more mildly that "too much masturbation was bad."

When he was about 13, he went to several parties at which kissing games were played. He was completely unexcited by the ac-

tivity, which he merely engaged in to avoid comment. He sensed that something was wrong in his lack of response. He has been very friendly with an attractive girl since their adolescence. Although he is very fond of her and has spent a great deal of time with her, he had never wanted to kiss or caress her. Because of these observations and his fetishistic fantasy life, he began to consider himself a "weird" case, and became increasingly concerned about people considering him homosexual. He continued to "court" this girlfriend as a sort of protection against such a conclusion. He was well aware of his lack of reaction to the woman's body. It neither interested nor repelled him. He wondered whether his mother's constant and careless exposure of her body had interfered with the development of a natural curiosity about the female body. He had no interest in the details of female sexual anatomy. He never gave it a thought, considering it foolish to inquire about it or seek information from a book. Talk about sex, as in jokes, he considered vulgar, and he would blush at his father's occasional racy remarks.

He had always felt inferior and inadequate intellectually, as well as in regard to so-called manly abilities. He had a constant fear of making a fool of himself. He felt dull, lacking in personality and charm, unlike his parents, especially when in the presence of strong, impressive, and extravert people. He envied and feared such people. He was particularly uncomfortable with, and hostile toward, a maternal uncle who was his mother's favorite. He was a bright and outgoing person, who actually was very friendly toward the patient.

Awareness of his sexual difficulty caused the patient to become increasingly uncomfortable and insecure with people. He had always felt that his face had a moronic look, because of a peculiar upward slant of the outer canthi, giving what he considered to be an unusual appearance to his eyes. He became increasingly self-conscious about this peculiarity, which augmented his fear of being considered stupid. He had had irregular early schooling because of his poor health and the resultant frequent changes in inadequate private schools. This handicap revealed itself when he entered the public schools at 10. He made poor grades until he reached high school. He had difficulty with reading and mathematics, and his parents showed their displeasure and disgust

over his need for help. His general feelings of inadequacy were increased by the other boys considering him a "sissy" in school games. When he began to get better grades in high school, he considered they were mistakes. Even after his graduation from college, his feeling of "stupidity" persisted. He was afraid to volunteer that he was a college graduate, feeling he was not adequate to such a status.

His greatest sense of accomplishment and adequacy, he achieved in dramatic activities in school and in summer stock theatricals. He was greatly interested in acting, and he got his highest grades in public speaking courses, although he was very nervous about such an activity. His greatest ambition was for some career and recognition in the theater. His hobbies were of the cultural variety, such as music and painting.

He has always been aware of his fear of competing with other males. He is both fearful and jealous of those who are aggressive and successful. He shrinks from such people. "I don't want to compete with a fellow for a girl. Why would she have me when she can have a regular man?" He once read that fear of the man's world is one of the factors making for homosexuality. He felt that this applied to him. He related this thought to a dream in which he is looking for a girl but ends up with a man. He feels superior to an effeminate, overt homosexual; but, when with a "nice regular fellow" whom he would like to know, he feels profoundly inadequate. His remark about this was associated with a dream in which he is driving a car, but is not certain that he can do so. He recalled that he failed a driving test recently.

He told of trying to make love to a girl who was somewhat inebriated. He felt at the time that he was trying to demonstrate that he was a man. This episode was recalled in association with a dream indicating his wish that a woman make no demands on him to satisfy her. With his few male friends, he resorts to fabricated accounts of his heterosexual exploits with the two girls whom he sees constantly on a most platonic level. They are both very attractive, and he is proud to be seen with them. He is fond of them, and has interests in common with them, since they are both seeking theatrical careers. Nonetheless, he recognizes that they serve as a "cover" for him.

When he entered therapy, he was unemployed, having just been

graduated from college. He was struggling with the need to seek employment. But he passively waited for help from his father and his friends. After a year, he managed to find a job, but allowed his mother to dissuade him from accepting it, on the grounds that it would interfere with their dinner hour! It was another half year before he got another job—on a level much below his educational qualifications. During his few months of work in this position, he became very friendly with another young man from a more modest background, who regaled him with tales of his heterosexual exploits. The patient replied in kind with fabricated stories. He had frequent fantasies of this friend in the midst of all kinds of difficulties in which the patient came to the rescue in true hero fashion. He was very eager to impress this fellow worker that he was a "real man." At this point there occurred a dream in which he was in bed with a woman, but was quite bewildered by the situation. He remarked: "In reality I try to act like a man but I am not."

Through his work, he became friendly with a somewhat older woman, with whom he finally engaged in "mutual nudity," his "first physical contact with a female body." He was excited to the point of erection, but intercourse was not attempted, since she would not permit it. He was only mildly excited, and noted no interest in her feet. Later he masturbated with fantasy of intercourse with this woman. About this time, he dreamed of an aggressive woman initiating him sexually.

After several months, he sought, on his own, and found a better job—one connected with the theater, which he desired very much. He greatly feared its greater demands, however; it called for numerous personal contacts with important theatrical figures. Although severely threatened and with deep misgivings, he accepted. He felt that there was something "nondescript" about him, that no one would recognize him again after an introduction. He was also concerned about being considered homosexual. With encouragement, he persevered, became increasingly more competent and gained immeasurably in self-confidence. It was his impression that much less time was spent in fantasy and that fetishistic images were rarely about his father's feet. He dreamed of seeing a big man, "like my father" without a penis. He also dreamed of driving off with a girl in a powerful car. Actually

he had not yet passed a driving test for his license. He dreamed that he had a large penis which made him readily desirable to his girlfriend. And then he had his first dream of heterosexual intercourse. In it the girl said he was too heavy, bringing to mind that his father is a very heavy man. An "identification" with the father is becoming evident.

At this point ironically, the psychotherapy was interrupted by a large bus whose back wheels mounted a sidewalk on which the patient was waiting, and fractured his right tibia and two metatarsals, requiring open reduction. The situation was complicated by ensuing bone infection; and the patient has been unable after six months to resume therapy.

Discussion

In his struggle with the problem of fetishism, the author noted in the foregoing review, that no picture of the fetishistic patient —of his personality—emerged from the studies reviewed, except for some suggestive glimmerings here and there. From considerable reading and from work with the case reported here, it became clear to the author that fetishism is not merely a narrow aspect of psychosexual development, and is not merely a sexual practice, but is a segment of a way of living "motivated by a special kind of consciousness." Allen made a similar observation from a somewhat different viewpoint in his paper on homosexuality.[32]

It appears that *what is common to the triad of homosexuality, fetishism, and transvestism* (all of which are represented in the foregoing case) is not the fear of castration, as postulated by Fenichel, nor escape from the woman, as Romm thinks, but rather is *the fear of the male social role in its entirety in the face of an overwhelming sense of inadequacy and a low self-esteem.* To borrow Allen's words, "basic in the whole homosexual problem is the inadequate and insecure feeling about the self." The abysmally low self-esteem of the fetishist is amply set forth in the case history reported here. This history and the cases in the literature which are sufficiently informative reveal the fetishist as an insecure, passive, dependent, and inadequate male, whose auto-erotic and diminished sexual activity is simply a reflection of his general inactivity. As Romm remarked, "their method of adaptation is to symbolize and substitute rather than to carry out the under-

lying desires," to live on a fantasy and spectator level, vicariously, by proxy. This is the result of a way of life, not the working out of atomized instinctual impulses like scopophilia. The problem in each case is to determine what fostered the development of this special way of life.

Normally in the course of growth and development, the child is aided in achieving a sense of adequacy and independence. It is well known that illness in the child fosters maternal overprotection and oversolicitousness, with resulting prolongation of a dependent status and its detrimental effect on self-esteem. The patient in the present case was a premature baby, weighing only three pounds at birth. This fact would intensify concern about him. But in addition, his early years were characterized by prolonged somatic illness, requiring special and restricting measures, such as private schools—all calculated to foster dependency. Any attempt to rebel against the oversolicitous regime, with its governesses and maids, was severely squelched by his mother, even by the use of physical punishment. His mother's relegating him to the care of others and the liaison she carried on for many years only strengthened his need and pushed him into a world of fantasy, by threatening his dependency on her. His essential loneliness permitted the tendency to retreat to develop apace.

His father's overwhelming masculinity, with its insistent demands that the boy perform the male role adequately and its contempt and disgust at his failures, only furthered a sense of inadequacy and futility. Even the pressure toward identifying with his father, and striving toward the appropriate social role, was uneven because of his father's prolonged absences. He was thus thrust deeper into the environment of women, all dedicated by inclination or hire to reinforce his dependency. As noted in a paper by Ovesey the dependent male is engaged in a constant struggle to salvage his self-esteem.[33] The male role he feared to essay, he could create endlessly in fantasy. His loneliness and periods of isolation with a governess supported his retreat to a world of make-believe, play-acting and appearances (interests in the theater, movies, and photography). In his fantasy, he was able to marry, to plan this male-female event to his heart's content and down to its minutest detail. In fantasy, he could bring fulfillment to a maiden aunt and an end to loneliness with an

imaginary sister. There he was able to win the approval of his much-feared yet much-respected father and thus salvage his self-esteem. Which brings the discussion to the fetishism and its function in the life-pattern.

The outstanding characteristic in the behavior of this patient, which was maintained throughout most of the analytic work, was his obsequious, ingratiating, almost fawning manner. This characteristic is imbedded in the fetishistic fantasy, for the desire never was acted out, as was noted. It should be recalled that parent-figures were paramount in the development of the fetishistic pattern. It is suggested that, in his fetishistic practice, the patient is seeking to gain the favor of the father, the athletic and effective father, by ingratiatingly relieving him of pain. Through the ages, the foot has been associated with servitude, with the role of slave and master, ruled and ruler. The monarch's foot is still being kissed as a sign of obeisance and submission. "Kiss my foot" is a vulgar phrase of derogation. To take off the master's shoes and to bathe his tired feet, are matters associated with the service given by the menial, or in some cases by the wife. To drink wine from the slipper of the beloved is slavish, masochistic adoration, seeking favor in her eyes.

It is suggested that the fetishist is a passive, dependent individual of extremely low self-esteem, who seeks slavishly in fantasy to win favor and acceptance. Feeling inadequate to the full role of the male, he serves the woman adoringly, religiously or slavishly, to gain her love and her tolerance for his inadequate performance. In the case of the homosexual fetishist, he serves the man to gain his own acceptance as a male and thus is permitted to salvage his self-esteem. In masochistic fantasies, as in a case of such fantasies recently studied by the author, there is the notion of being the handmaid to a woman in a slavish manner.

In the case discussed, there are several psychological elements condensed in the fetish ritual. The pain in the imagined foot may represent the hostility toward the overpowering father-figure. The ability to remove the pain by rubbing not only wins the favor of the father, but gives the son a sense of power, the assurance of his ability to give pleasure to someone else. The fetish, rather than representing the imaginary penis of the postulated phallic

mother, symbolizes the paternal phallis as the emblem of adequacy in all areas of the male social role.

Finally, one more suggestion. It has long been known that foot and shoe fetishism predominate in the aberration, and in classical theory this is due to the foot's resemblance to the penis, among other considerations. It seems to the writer that the concept of the fetish as part of a slavish maneuver to win favor and acceptance might better account for the predominance of foot and shoe fetishism. To develop these speculations at length would require the prolongation of a paper already rather long. They are left, therefore, for further study and elaboration.

SUMMARY

This paper reviews the analytic literature on fetishism, presents in detail a case of homosexual foot fetishism, and offers some new approaches to the problem, some of which may be considered speculative.

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THE FEELINGS OF A FETISHIST*

BY "BOOTS"

Affectionately Dedicated to My Friend, T. H.

Perhaps unknown thousands of persons go through the greater part of their lives believing, that because they feel themselves to be radically "different" in one way or another from the majority, this makes them outcasts in the view of their fellowmen. The majority of mankind cannot possibly know about the unusual peculiarities of these unhappy individuals with "guilt complexes." However, persons acutely aware of the fact that they have abnormal quirks in their make-ups know that the general public which naturally distrusts what it does not fully understand, would instantly condemn them, if there were general knowledge about the concealed character defect. Such "different" persons—and certainly there are a great number of them—may feel, especially if some phase of the phenomenon called sex is at the root of their difficulties, that they live figuratively behind "an iron curtain of sex."

They may tend to identify themselves with miscellaneous outcasts of various types, feeling that they have something in common with every socially rejected person on earth.

A Negro may feel that many look upon him as a pariah solely because of color, which he is in no way responsible for; yet an unfortunate brand of "superior-race thinking" in past generations, caused thousands to look upon members of the colored race as no more than mere animals, fit only to be slaves, to be treated like beasts of burden.

Many Jews may feel that society "scorns them" simply because of their reputed dishonesty in money matters, or other obscure reasons, or for no other reason at all except that they are just Jews.

Persons of sincere religious beliefs have been persecuted, and

*This paper is written by a self-professed, homosexual fetishist. He cannot be called a patient, for he is not under psychiatric care and appears to have made an adjustment to society under which he is able to function satisfactorily to himself. THE QUARTERLY is not, of course, in a position to guarantee the authenticity of this report; but, aside from internal evidence in the manuscript itself, which tends to mark it as authentic, the author supported it by submitting an extremely convincing, if small, collection of notes and exhibits.

still are, because they hold religious views that are different from widely accepted orthodox beliefs.

Intolerance, or false concepts of any kind, cannot be eradicated overnight, or with the suddenness that an electric light switch is snapped on to flood a dark room with light.

Thus, unfortunately, far too many persons may feel acutely that they are outcasts of one kind or another because of physical, mental or moral qualities that differ from those of other segments of the population. And it is paradoxical in a way, and also unbecoming to any clear-thinking minds, that one group which may be considered anathema, will violently condemn another part of society which is "in the same boat" and "on the same sea." Perhaps some of our much-vaunted claims to being a nation possessing a high standard of culture and educational maturity are open to question.

The writer of this article feels himself to be "among the damned" because he is a *fetishist!* His own motto is, "Live and Let Live," just so long as an individual's right—guaranteed by our American Constitution—to "seek the pursuit of happiness" does not harm another person in any way, nor infringe upon another person's right to find happiness, wherever it may be found. Whatever is needed to gratify the special physical or psychic needs of some individuals may appear to folks in general as being as peculiar a dish as honey and red pepper over stewed catfish. That "one man's meat may be another man's poison" is true, not merely in regard to nutrition, but in the broad and diverse field of sexuality as well.

Fetishism, in all its various manifestations, is too broad in scope to be covered in one brief article. Persons desiring a detailed study of the phenomena should read the two volume work, *Sexual Aberrations,* by Wilhelm Stekel.

What is a Fetish?

A fetish is usually, but not always, some inanimate object toward which a person is unconsciously and irresistibly "drawn" on a similar principle to that by which iron objects are drawn to a magnet. Nails *cannot help* being drawn toward a steel magnet. In like manner, fetishists *cannot help* being excited, stimulated, or sexually aroused by their fetishes. Fetishes are

rather often articles of clothing, or footwear, but may also be some part of the body of another person.

Generally speaking, all men are fetishists in some slight degree. Thousands of normal American males make fetishes of women's breasts, and derive their biggest vicarious sex thrills from observing the female bosom.

The possessor of a fetish may experience much pleasure with the object of devotion much as a child would experience pleasure with a doll. Little girls talk to their dolls, and fondle and kiss their "make believe babies." To a child a doll becomes a substitute for a real baby, and satisfies a child's natural instinct of motherhood.

A fetish, to a person grown up physically, may represent a symbolic substitute for a real person. A fetishist may attribute to his fetish the imaginary or real qualities that he believes exist in some person he loves. This may be done by means of "games of pretending." For example, a homosexual might be in love with a man named Henry. Perhaps the homosexual gets a chance to wear Henry's boots, which to the borrower have become a fetish. The homosexual deviate may speak to the boots as if the boots were Henry himself, for instance, "Come on, Henry, let's you and I go for a walk." Or fondling, and secretly kissing the boots, the sex deviate might say, "Henry, old boy, I love you very much." In other words, the fetish becomes a love substitute, or a case of love by proxy! The fetish, in such a case, must *necessarily substitute* for the love partner if the latter is *unknowingly involved* in a case of *unrequited love!* Fetishism, in this instance, would actually be, from the emotional viewpoint, a homosexual tragedy!

There is a word, "monomania," which the dictionary defines as, "insanity on one subject only." Because of this particular affliction, it is possible for fetishists to be "raving mad" about their fetishes, but outside of an irresistible, compelling obsession for them, be in all other respects, as intelligent and sane as the president of the United States.

My Own Case History

I am a homosexual, who did not develop emotionally that "natural interest" in girls which all so-called "normal" boys experience. An expression boys often use in speaking of a pretty

girl, "Golly, ain't she a honey," did not register in my mind at all. I really could not understand what the shouting was all about. Because I could not understand this emotional interest in girls that other boys possessed, and since the other boys were puzzled at my lack of interest in girls, I felt at the age of 14, insecure, out of place, and extremely inferior to all other boys of my own age. With the advancing years, I became more detached from the group and withdrew more and more into a turtle-like shell of retrospect and solitude.

My mother had passed away when I was nine years of age. Father and I lived alone on dad's farm after mother's death. My early playmates were strong, husky, healthy, attractive farm boys whom I secretly idolized. They often wore *rubber knee boots,* not only on the farm, but also to school. During one school term when the classroom was overcrowded, it was necessary for two pupils to share the same seat and desk. I was thrilled when the teacher thoughtfully assigned to share my seat with me, a charming, roguish, fellow who often wore to school a pair of handsome, brown rubber knee boots. This fellow, partly in fun, and partly to tease me, often gave me some very wonderful "bear hugs."

At this point I will state that a fetish is often a "throwback" resulting from early childhood memories which are especially vivid. The emotional or mental seeds of fetishism may be unknowingly planted in infancy and childhood, only to grow and develop many years later when certain conditions are conducive to the development of this eccentricity of behavior. I think most medical doctors recognize this truth in regard to numerous diseases of the human body which develop insidiously, such as ailments caused by vitamin deficiency. This is one reason that preventive measures are stressed so strongly in medicine.

To continue with my story, my early childhood and schoolday pleasures largely became associated with the rubber boots my playmates wore. When wrestling, I would usually end up by being "the fellow underneath," and the victor (I was secretly happy to have it so) would clamp my feet between his booted legs. Or I would deliberately push my head between a boy's boot-clad legs, and, with a fancy "squeeze play," he would stanchion my head between them, like a cow is stanchioned in a dairy barn.

As a boy who may have been born as what is known as a "congenital homosexual" with inborn "masochistic tendencies" (deriving pleasure from pain), I secretly enjoyed any rough treatment from my beloved pals, and was content to be subdued by them.

This is how my fetish, which is *men's or boys' rubber boots,* especially knee or hip boots, originated. Memories of these early childhood incidents inspired these poetic lines.

"Just stray, sweet bits of happiness,
Scattered through the years gone by;
With *Boys in Boots*—their kind caress,
These memories cannot die!"

Through the years, my fetish became to me a symbol for many things. A lion may be used as a symbol of courage, a white dove as a symbol of peace, an evergreen tree as a religious symbol of eternal life, or a skull and crossbones as a symbol of death. For me, *men's rubber boots* became a symbol of *superior manhood!.* This symbol of mine, exemplifying to my erratic mind, *mental superiority,* is worn by hard-working farmers, courageous firemen, and fishermen who risk their lives for a living—like the famous fishermen of Gloucester in whose memory Gloucester, Mass. erected an inspiring monument. So my fetishism is, in one respect at least, a form of *hero worship* that is deeply entrenched within my mind. To excommunicate these ingrained thoughts from my mental faculties is not too feasible.

Desire Grows Stronger

One day I worked for a very attractive, young farmer, who, like most farmers, frequently wore rubber boots. Hidden within my heart was my ever-existent, homosexual longing for love and affection from someone of my *own sex.* The farmer offered to lend me his hip boots for a special job he wanted done. I was thrilled at the chance to don them. Pulling them up over my legs as far as they would go satisfied a secret longing of mine. Being in my *buddy's boots* was the next best thing to being in heaven, so my foolish mind thought. They gave a feeling of being more virile, more masculine, more energetic, and *more like the one I loved,* but I could never let it be known. The words of a song, popular during that era, flitted through my mind.

"Never to feel your kiss,
Never to know such bliss—
Never to hold you in my arms,
Never to know such charms!"

This sad fact, repeated countless thousands of times, in the homosexual world of *unrequited love* is, after all the *genuine tragedy* of inverted sex impulses, and the only real curse perhaps of being a homosexual. Homosexuals have no desire to be *cured* as the term is used in reference to the cure of some such bodily disease as cancer. They have no wish to conform to standards *alien to their nature!* Like each human being they want, *not* to be adapted to society, or even to creation, but to have their feelings adapted to suit their own personal needs and desires. They do not yearn for some miracle of science which will place them among the normal. Many a homosexual seeks the comrade and the lover of whom Walt Whitman sang:

"For the one I love most lay sleeping
in the cool night . . .
And his arm lay lightly around my breast.
And that night I was happy . . ."

It is only natural that, once having tasted a certain pleasure, there will be a desire to taste the same pleasure over and over again. Having got the feel of one farmer's boots, I was from that day forward, tormented with *curiosity,* and suffered unfulfilled yearnings at the sight of any man or boy wearing *rubber boots!*

To me it was always a case of heaven out of reach. I was so often *near a goal,* but unable to attain it. I felt like a starved person being at a banquet and seeing many delicacies, but unable to partake of the food. Or like a dog that is tied just out of reach of a nice, juicy bone. The often-repeated mental torment of this strange hunger caused a homosexual fetishist to pen the lines . . . "the gods were angry the day I was born, and this curse they placed upon me: you shall want, and want, but NEVER HAVE, you shall suffer eternally!"

The Coming of a Friend

The feeling of peace and relaxation that a farmer's boots gave me so long ago is an emotional goal I have vainly striven for

through the years. *Normal men* cannot comprehend, or fully understand, any odd, unusual feelings of this sort that are entirely foreign to their own natures. Even homosexuality itself is, to them, a weird phenomenon that they do not understand.

However, some persons do exist who possess that rare gift of profound understanding when it comes to sensing the secret sorrows that shroud the lives of many folks.

I have been more fortunate than a majority of sexual deviates in having found a *friend who understands.*

The lives of two persons who are entirely different from each other may be plagued by separate griefs. But the fact that each one has a burden of unhappiness to bear may become a *bond* to help "unite in sympathy" two persons of widely differing characteristics. My friend who is the most capable of understanding my intimate feelings is a Jew. He is also a normal, married *heterosexual* person with an independent business of his own. If I had not found this friend, this story probably would never have been written. It is, in part at least, a dedication to the truest friend I have ever found, or could ever hope to find. This friend is one who fully fits the best definition of a true friend that I have ever came across: "A true friend is one who knows ALL ABOUT US, but still remains our friend."

Pathology of an Obsession

One of Shakespeare's characters once said, "There are more things in heaven and earth, Horatio, Than are dreamt of in your philosophy." This truth is emphasized by thoughts of the extraordinary emotions which the sight of men or boys wearing rubber boots arouses in me. These persons are innocently responsible for the weight of a secret cross I bear. However, it can never be otherwise, and my life's mysterious sex burden might be called *bittersweet,* inasmuch as it brings me concealed pleasure, as well as hidden mental vexation.

The many unfulfilled desires to don and wear, or even just to "touch with my fingertips" the *tantalizing boots* that I see other males wearing, generate within me powerful feelings of *sex frustration.* This is the cause of an everpresent abnormal sex hunger or craving. In a way, it is somewhat like the craving

of a dope addict for the drugs he must have to help keep him rational.

There is a saying, "The grass always looks greener on the other side of the fence." For a boot fetishist, this saying might read, "The boots I have not yet known may hold greater pleasures for me than any I have previously handled." This is the unhealthy, unwholesome, pathological condition of my "sickness of fetishism."

Curiosity thus becomes a "devil of torment." It once killed a cat, it is said. It may, or may not, kill me, but it does act as a *constant reminder* of my *odd anomaly* always kept in *sharp focus* by seeing men wearing rubber boots which I so eagerly desire to have just long enough to explore the subtle joys of them.

This creates an overwhelming sense of futility and "unworthiness," and is a prevalent source of mental depression and nervous irritability. If a man wearing rubber boots asks me the question, in perfect sincerity, "What makes you so nervous?" naturally one cannot bowl the man over by giving him such a very surprising answer as, "Your boots are driving me crazy!"

Is Treatment Available?

A great depth of tolerance, plus understanding, along with the healthy spice of a little "sense of humor" is needed in treating many psychiatric problems. Ordinary persons lack the training and education, or the *insight* and *courage* to cope with any problems which do not particularly seem to apply to their own lives. Thus, the problems associated with "mental illness" are left for the doctors, the psychiatrists, and the mental health groups. The average person has not yet waked up to the fact of the contributions that ordinary individuals can make toward better mental health, and toward helping to cut down the tremendous expense resulting from mental illness in the United States.

Some diseases are recognized as *incurable*. But even for incurable diseases there are palliatives which can make them easier to bear, even though the palliative is no more than sympathetic understanding. A psychiatrist once told a patient who came to him with a problem of fetishism, "If you can't fight a fetish, indulge it."

Because I happen to be a homosexual, the reader should not

get the impression that all homosexuals are necessarily fetishists. *They are not!* Circumstances in my individual case merely led up to the development of my strange obsession. There are, in fact, as many individual differences among homosexuals as there are among heterosexuals, and many heterosexuals are also fetishists, although in their cases the fetishes pertain to something or other belonging to the opposite sex.

Fetishism, in part at least, is a result of "mental conditioning" and of physical associations with the fetish over a long period of time. Mention *ice cream* to a child and the child may smack its lips in anticipation of something to be greatly enjoyed. The child may indulge in the delicacy to excess, and become deathly sick. For a time after this, it may have no appetite at all for ice cream. But some day its natural appetite for this favorite food will return. So with *sex*, the hunger may often be satisfied to *excess* but never entirely destroyed.

Once a fetishist, always a fetishist! is probably a truth that no physician or psychiatrist, scientist, biologist, or psychologist, can ever change.

Life's Greatest Gift—A True Friend

Truth is not discovered by a stubborn refusal to search for it because of prejudice, a superior "know-it-all" attitude, or preconceived ideas tightly clung to. Humility of spirit is necessary before one can begin to separate the wheat from the chaff. Much that is good in this world is easily overlooked because of that old bug-a-boo which often parades itself under the guise of *intolerence*. Here is an example of how good may be overlooked. Take a plain, white unruled sheet of paper. With a fountain pen make an ink splotch in the center of it. Show the paper to various persons and ask them, "What do you see?" The answer will invariably be, "A blot of ink." Few, if any, will say, "I see a lot of *white space*," although it covers more of the paper than the small ink splotch. But no one can deny that the white space is *there*, even though one does not recognize it.

A fact is a fact, and is going to remain, regardless of how ill at ease, or uncomfortable it is bound to make some people. Since "disconcerting facts" do exist, we cannot escape them, or run away from them like an ostrich that is supposed to feel secure

from danger by hiding its head in the sand. In the *final analysis* it is always best to accept truth *once we recognize it!*

My real friend accepted what was, to him *a new truth*. He was told about my passion for men's boots. He had no previous knowledge on the subject of fetishism. There was no preconceived prejudice against this "mystery of sexual deviation." With a sense of humility, knowing that each man has a weakness of some kind, he accepted the truth of my strange and haunting obsession. Outside of this sexual deviation, he knew I was in *many other ways* not too greatly different from many other men.

My friend did not add to the weight of "my secret cross" by shunning me as a *pariah* because of a sex obsession that brings me much unhappiness. Instead, as a *true friend* he has done what he can for me. He has taught me to adjust myself to my affliction of peculiar mental torment as completely as it is perhaps humanly possible. He possesses that rare depth of understanding which provides my ailment with palliatives to ease my "fetishistic hunger" whenever I find it necessary.

My friend knows that "If a hungry man cannot have a WHOLE loaf of bread, then he must be satisfied with the crumbs that fall from it!" He understands the true meaning of this statement IN A SEXUAL SENSE. He knows that all physically attractive men are, to me, like the loaves of bread the hungry man cannot have. I can NEVER BE LOVED BY MEN in the manner that women are loved. It is these OUTWARD SIGNS OF AFFECTION, hugs and kisses, and words of tender endearment that I, a homosexual, have hungered for in vain throughout my stormy life. In my case, RUBBER BOOTS seem like a very appropriate symbol for A STORMY (emotional) LIFE!

As bread crusts or even crumbs are a PART OF BREAD, so to me, in a symbolic way, MEN'S BOOTS represent a "part of the men I love." Men's boots are to me, THE CRUMBS OF LOVE with which I must vainly seek to satisfy MY EMOTIONAL HUNGER. With COMPLETE LACK OF UNDERSTANDING about this "hidden sex hunger" of mine, MEN WITH BOOTS permit me to "starve in the midst of plenty" and even DENY ME THE CRUMBS that they might freely give.

Only my true friend understands this STRANGE HUNGER. Through "love by proxy" (my fetishism) I not only share a part

of him, but share a part of OTHER men as well, EVEN THOUGH THEY LACK UNDERSTANDING. My real friend knows that I take to men's rubber boots "like a duck takes to water." Knowing that these cast-off articles of footwear are a PECULIAR TREASURE of mine, he collects all he can obtain to give or sell to me as SENTIMENTAL KEEPSAKES that symbolize my tragic and unreturned LOVE OF MAN FOR MAN. Maybe a few pairs of old boots come from the worst rogues this side of County Cork but "a hungry, pitifully starved dog is not apt to be particular whether friend or foe throws it a piece of juicy meat, or an especially appetizing morsel!"

This is the *true understanding* that does not condemn, ridicule or scorn. It is the understanding wherein a friend has spoken the comforting words, "I am glad you enjoy having my old rubber boots." A *sense of humor* between us but binds more closely the "ties of true friendship." "Don't be too hard on those boots" is a typical comment of his. As sentimentalists cling to objects that are actually worthless trash in many instances, so I hold on to the worn-out boots of a friend which never seem to lose the subtle fascination they hold for me.

A morbid obsession? Undoubtedly, it is. But whether gratified, or not, it seems certain in my mind that this obsession would still exist. To repeat what the psychiatrist told the patient (Incidentally, I was not this person): *If you can't fight a fetish, indulge it.* That is, so long as no one is harmed by it!" A wise and noted doctor who has written many illuminating books on sex once suggested to me that I sort of make a hobby of collecting men's old rubber boots as he saw no harm in it. This has been tried *publicly* without much success, for psychologists know it to be a truth, that what people *do not understand* they either ignore or condemn. However, this fact but makes the old boots of my friend all the more endeared to me.

My friend is *not a psychiatrist*, but he has done more to contribute to my happiness and peace of mind than any psychiatrist trying to chase elusive bats out of the belfry possibly could. I say this with all due respect for the psychiatric profession, believing that psychiatrists are necessary in helping to combat many of the ills of mankind. But wherein I previously stated that all men are fetishists to some slight degree, so likewise,

many ordinary, everyday people, without actually intending to be so, are psychiatrists to some slight degree, because of the contributions that they daily make toward human happiness.

Like the religious tolerance expressed in a religious song called, "You Go to Your Church, And I'll Go to Mine, But Let's Walk Along Together," my friend is an example of *sexual tolerance.* If he privately thinks that I am one of *nature's jokes,* or that I am one character in a million, it does not matter. I can easily overlook any *heterosexual shortcomings* he has, for people who live in glass houses should not throw stones. He also can overlook my homosexual way of life.

It is a case of "peaceful co-existence" between two persons whose sexual emotions are as different as night is from day. In more ways than one, my friend is truly one man in a million, for veritably he is *one in a million* who fully understands the *PRIVATE FEELINGS OF A FETISHIST!*

c/o The Editor
THE PSYCHIATRIC QUARTERLY
1213 Court Street
Utica, N. Y.

EDITOR'S NOTE

In the introductory footnote to this paper, it was remarked that, while the editors were in no position "to guarantee" its authenticity, the author had submitted a small but convincing collection of notes and exhibits. Not only because they tend to support the genuineness of "Boots'" story, but because they cast considerable light on the working adjustment he reports having made with his environment, and because they may throw, in addition, some further light on the dynamics of his fetishism, the pertinent material is summarized or reproduced by the editors here. This is with the full permission of the writer, who suggests that the account be called "the antics of a fetishist (with a sense of humor)."

"Boots" lives on an RFD route in a small town (less than 3,000 population) about 50 miles from the nearest large city. He collects rubber boots under the guise of part-time trading in scrap rubber, and by explaining his boot collection as a hobby. He appears to have achieved at least toleration, though a reading of his com-

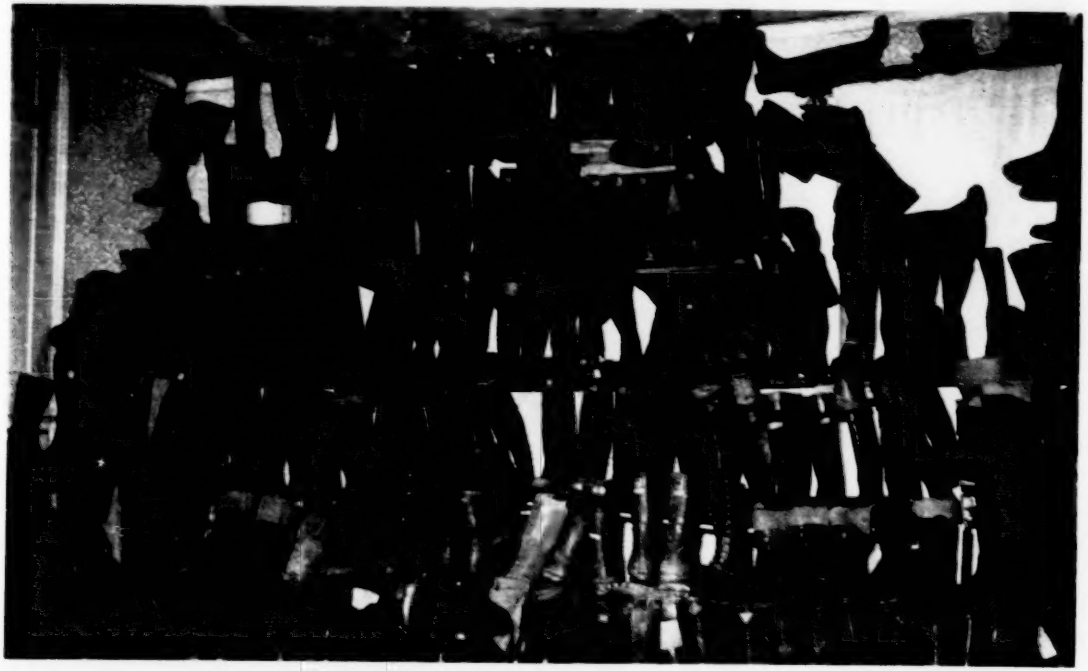
munications between the lines suggests that he has met a good deal of rejection as "queer" in more than the sense of being homosexual. It may be suggestive that friends are not too numerous, in that he emphasizes in his letters, *"Credit should be given to my one true 'down to earth' friend* who has *made possible my treasured boot collection*—and *gone to great lengths* to obtain old boots for me—on some occasions even buying new boots and swapping the new boots for some old *especially desired pair!"* It will be remembered that "Boots" asserts in his own article that the friend is a normal, heterosexual, married man with children, who supplies old rubber boots to the author as a dealer and, as "Boots" writes in a letter, out of *"rare insight, sympathy* and *understanding."*

With the author's permission, THE QUARTERLY communicated with the friend and supplier, asking if he cared to comment on "Boots'" fetishism and his own role in supplying boots. He writes:

"Although not being a homosexual fetishist myself and not having the pleasure of meeting ——— ——— personally, I have corresponded with him and have sent him dozens upon dozens of old pairs of men's rubber boots since this time of year back in 1951. It all started when I saw an advertisement of his in a farm magazine. It so happened that the first pair of boots were an unusual brand, besides appealing to the instincts of his peculiar nature. His very prompt and generous payment and friendly letter prompted me to send more and more boots, although I did not know for some time why or for what he wanted old boots. It was none of my business anyway. When he did tell me of his fetishism, I had a sympathetic and personal understanding. So I have been on the lookout for old boots to send to ———, not for just the dollars and cents part, but my motto has always been 'Live and let live.'

"I was as a boy very shy and bashful, self-conscious and would rather be alone than in company or a crowd, especially those of the opposite sex. I remember when a small boy I used to put on my father's big rubber boots and tumble around in them, and draw them over my head for a hat, etc. I collected all the old rubber boots I could find in the dumps and any other place to sell to the junkman.

"These were only passing childhood fancies which were not outgrown but gave me a sympathetic insight into the personal feel-



PART OF A FETISHIST'S COLLECTION

The author describes this photograph as "A Tribute to a True Friend," the man who has collected most of his boots for him. He adds that "countless hours of pleasure and relaxation," which the picture represents, "would not have been possible had the 'old boots' fetishist not found the friend to whom his story is dedicated.

ings of Mr. ———. Although sexually different, we still have much in common. For as Mr. ——— once wrote me, "If it were not for my seeming misfortune of possessing a peculiar sexual aberration, I am certain I would never have known what it means to have a real friend. So in some ways my passion for men's boots has been a Blessing in Disguise and in the vast field of those who profess to be friends has helped me to separate the Wheat from the Chaff.'

"Mr. ———has an especial passion for men's' red rubber boots, both knee boots and most of all old hip-boots, also white boots. I have never been able to locate any red hip-boots for him, and I hereby request any person reading this article to send him some if they know of any available. He has never returned any boots to me and has been satisfied with most I have sent him and has always paid me like a gentleman."

"Boots" has submitted a picture of "part" of his collection of more than 200 pairs of rubber boots. They are arranged in the corner of a room and on shelves. (See figure.)

Besides supplies from his dealer friend, the author writes that "through the media of mail order advertising and exploitation I am able to commercialize on my obsession due to *a psychological truth* that 'what folks *do not understand* they *reject*.'" His letter adds, "See enclosed sheet—'WANTED: MEN'S OLD RUBBER BOOTS.'"

The "enclosed sheet" also shows, attached, clippings of classified advertising and a boot collection snapshot. Under the heading of "WANTED TO BUY," is the following advertisement, apparently from a weekly newspaper:

> 50c A Pound Paid for Scrap Rubber. Shipping instructions 35c. Blank Blank, Blank Town, Blank State.

Another classified ad, this one apparently from a farm journal, reads:

> WANTED TO BUY: 50c a pound paid for articles most farmers junk yearly. 10c (to eliminate the merely curious) brings complete information. P.O. Box ———, Blank Town, Blank State.

The first advertisement is signed with the author's name and

address in full; the second, as will be noted, with a post office box number (incidentally, of a different town). The "shipping instructions which are offered in the first advertisement for 35c consist of a single, double-spaced mimeographed, typewritten sheet, on which "Boots" has noted: "An advertising example of HOW A FOOT FETISHIST COMMERCIALIZES on an obsession. This offer is SINCERE but since PEOPLE REJECT WHAT THEY CAN'T UNDERSTAND only about 1 out of 1,000 sends me any boots." Concerning the 35 cents, he notes, "This small fee gives me a little interest on my advertising expenditure." In the copy sent to this QUARTERLY, "Boots" has underlined in ink the fact that boots may be sent in "any condition with mud, milk splatters, debris, etc. clinging to them." Whether he underlines all copies for the benefit of his mail-order trade, or whether this underlining was to call attention of the editors to a condition of his fetishism, he does not say. The "instruction sheet" is signed with his full name and address. It reads as follows:

WANTED! MEN'S OLD RUBBER BOOTS:
(Shipping Instructions—35c)

Up to $1.00 per pound, in some cases, is paid for Men's and boys rubber knee, over-knee and *HIP BOOTS*, Boot Foot *WADERS*, full or part lace up pacs of TRADEMARKED BOOTS with name labels clearly visable. Non-Trademarked Brands are purchased at a lower rate unless they are a very UNUSUAL TYPE of boot. Buckle Artics, Dress or Work Rubbers, and women's and small children's rubber footwear are NOT INCLUDED in this offer. Basic reason for obtaining the boots is to obtain as complete a collection as possible of all TRADEMARKED BRANDS. Prices are based on the SCARCITY or ABUNDANCE of the Trade marked Brands available. MAXIMUM PRICES (50c per pound) are paid for all RED COLOR BOOTS regardless of trademark brand, or even NAMELESS red color boots, since this is the RAREST TYPE of all. Most wanted Brands of boots are Hood "Ike Waltons," Cocoran Fishing Boots, L. L. Bean's DUCK HUNTER HIP BOOTS, "Utica Knee Boots," Ball Band Vac RED KNEE BOOTS, Dave Cook's "Old Timer", Beacon Falls "Trouter", and Sears & Roebucks BROWN COLOR Boots which were sold some ten years ago. Over $100 has been paid out to *one man* for old boots he has sent me. Address of this person sent for 15c to cover mailing expenses and time involved in correspondence. All boots must be sent PREPAID as C.O.D. shipments will be refused. Payment for boots will be mailed within 10 days after receipt of them. Not necessary to write first but if you wish an EXACT QUOTATION PRICE you may write to

me first to obtain my BEST CASH OFFER. Minimum price paid is 10c per pound and MAXIMUM PRICE $1.00 per lb. which is only paid in SOME RARE CASES. WE ALSO PAY SHIPPING CHARGES ON THE BOOTS! Boots may be sent in ANY CONDITION with *mud, milk splatters, debris, etc. clinging to them* since most FARMER'S BOOTS are received in this condition. An EXTRA BONUS AWARD is paid EACH MONTH for the most interesting pair of the month, plus a GRAND AWARD at the end of the year for the most unusual pair of boots of the year. Write me, enclosing a self-addressed stamped envelope if you have further questions on this buying offer.

BLANK B. BLANK
(Buyer of *Scrap Rubber Boots*) Dept.—
Blanktown, Blankstate

"Boots" also encloses a second mimeographed sheet, which he labels "another way of commercializing on a FETISH." His ink underlining here emphasizes "devotee of masculine rubber footwear . . . *most strongly express . . . devotion* . . . toward their OWN boots or the Boots of their Pals . . ." Also ink underlined are "PLEASURE & BENEFITS" under paragraph 2 of the "Rules" and "Devotion toward boots" under "Winning Tips." "Boots" does not say how successful this soliciting has been; and what he means by "commercializing" is enigmatic—the project seems designed to be costly to the advertiser, not return a profit. The text of this circular follows:

$5.00 CASH FOR SNAPSHOTS
Submitting Instructions—35c

I buy Snaps of Men and Boys shown wearing rubber knee, over-knee or Hip Boots. $5.00 offered EACH MONTH for the most OUTSTANDING photo submitted during that particular month. Additional awards of $3.00 and $2.00 are also offered each month for second and third best photos. Snapshots are wanted for a collection of boot photos by a ***DEVOTEE of masculine rubber footwear.*** Photos will be judged MAINLY on the basis of those which MOST STRONGLY EXPRESS a sincere DEVOTION by men, either towards their OWN boots, or the *Boots of their* PALS except that all photos must be received by the end of each month for that months judging.

RULES

1. While any type of rubber boots may be used in posing for the "boots

on Parade" photos, 17 inch lace and part lace pacs, knee length, Storm King and full thigh length (hip) boots are the preferred choice.

2. Winning photos will be judged on the basis of humor, interest, and originality, as well as to how the various photos express the USEFULNESS of RUBBER BOOTS TO MEN from the standpoint of SERVICE, PLEASURE & BENEFITS.

3. All rejected photos will be returned. An UNLIMITED NUMBER of photos will also be purchased at 25c each in addition to the three major winners each month.

4. Write your complete name and address on back of each photo submitted. If possible, tell what brand of rubber boots you are wearing in the photos.

5. On a separate sheet of paper answer these two questions. 1. What is your FAVORITE BRAND of rubber boots? 2. What type of rubber boots do you like best for ALL AROUND WEAR? If you prefer LEATHER BOOTS to rubber boots please tell why.

6. Photos may be taken either indoors or outdoors, either of single persons or groups of persons, but only one person can win a prize in any group photo submitted.

7. Photos you had taken YEARS AGO of yourself in RUBBER BOOTS are acceptable. Whenever possible please give the date these photos were taken.

WINNING TIPS

Pleasure from boots could be shown by a Boy in BOOTS carrying a school lunch box and a FISHING POLE. Its title, "Playing Hookey" would tell the story. A man's pleasure could be shown by someone patching his boots with a big fish shown in the background. The man might be saying, "Old Boots, you've got to help me catch more PRIZE WINNING FISH." *Devotion towards boots* could show a man locking up a pair of boots in a steel safe while saying "My fishing pal told me to take GOOD CARE of his BOOTS while he is sick".

For additional information, if desired, write me enclosing a self-addressed and stamped envelope. Send all entries as soon as possible to—

BLANK B. BLANK, Photo Dept., Blanktown, Blankstate

The editors present this material, believing it to be not only remarkably illustrative of "Boots' " own paper, but of the scientific article, "Fetishism: A Review and a Case Study," by Simon H. Nagler, M.D., also in this issue of THE QUARTERLY.

Communication—

A CRITICISM OF A STUDY OF PROGNOSIS IN THE FUNCTIONAL PSYCHOSES

BY HAROLD BOURNE, M.B., B.S. (London), M.R.C.S., L.R.C.P., D.P.M.

Perhaps the greatest difficulty that besets psychiatry is that of ascertaining the value of treatment methods. While new therapies enter the scene all the time, the worth of even so long familiar a "household remedy" as insulin coma, for example, can be disputed, as recent polemics have shown.[1-4] Even a stout defender of insulin admits that no significant benefit has been "conclusively established,"[5] and in the best controlled trial so far,[6] it proved to be no better than barbiturate coma.

Some of the obscurities might fade if the natural course of untreated mental illness were known with any certainty. Work offering this information, therefore, merits every attention; and if it contains flaws, it is no less important to point them out. It is the purpose here to indicate a substantial error in work of this kind, the prognostic study of psychosis reported by Harris and others in a series of papers,[7-9] one of which[8] appeared in this journal.

Their material comprised all patients committed in 1930 to mental hospitals in the London* County Council group. Using the clinical notes made in the first week, they excluded patients over 40, and any with epilepsy, with brain damage or disease, or with previous treatment either in a mental hospital or for mental defect. The 632 cases that remained form the substance of an 18-year follow-up of "functional psychosis." It is an objection, if a minor one, that the Lunacy Acts in England by no means restrict their workings to people who are psychotic. A few of these 632 remaining patients must surely have been hysterics, destitute persons, problem drinkers, and other misfits.

The authors' most arresting findings were that, from the clinical descriptions alone, these 632 cases fell readily into three patterns of functional psychosis—affective psychosis, schizophrenia, and

*England.

"atypical psychosis"—and, furthermore, that this tripartite separation was valid because for each group the prognosis was entirely different. Incidentally, it emerges that the prognosis of schizophrenia was much the worst.

Here, anyone at all familiar with the clinical records of London's public mental hospitals 25 years ago may wonder how, confining themselves to the first week's notes, or even not doing so, the authors could have discerned vague pictures of illness for each individual, let alone pictures to be classified with confidence.

However, there is a far graver shortcoming than that one may be: the authors' unwitting disclosure that, among the very criteria distinguishing the three clinical syndromes, the outcome of the illness was one. Thus it was only to be expected that remissions were fewer in schizophrenia than in "atypical psychosis," when one characteristic of the latter was to be episodic. And clearly from one paper,[9] this certainly was sometimes the case, since it states (the Italics are the present writer's): "The third group, the atypical psychoses, cover a miscellany of *states* of excitement, stupor, hallucinosis, confusion, *episodes* of disordered conduct in individuals with clear evidence of psychopathic personality, and a small residuum in which it was not possible to get a reasonably clear picture of the clinical state of the patient from the notes following admission." Moreover, it is fair to suspect that this residuum must have contained patients who recovered quickly and were removed by their relatives before anything much could be recorded.

It is to reason by the fallacy of the consequent, as Harris and associates do, that their three clinical patterns of functional psychosis really are separate entities because they turn out to be prognostically different, when the clinical distinction itself could actually rest on the length or brevity of the illnesses—that is, on the different ways they turn out.

Probably, their category of "atypical psychosis" included schizophrenic illnesses peculiar only in their rapid evolution. When combined with these, the group classified as schizophrenic in this material of a past generation comes to have a prognosis less

gloomy than in the authors' presentation, and one offering less cause for confidence in therapies introduced since that time.

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Communication—

UNILATERAL TREMOR IN PATIENTS RECEIVING VESPRIN (TRIFLUPROMAZINE)

BY M. ZLOTLOW, M.D., AND A. E. PAGANINI, M.D.

A group of nine long-term, hospitalized, chronic schizophrenics were placed on "Vesprin" (trifluprom azine) in July 1957. The dosage was started in all patients at 10 milligrams, t.i.d., for 10 days and then gradually increased to 50 milligrams t.i.d.

Severe extrapyramidal symptoms developed in six of these patients, within three weeks of therapy while receiving 50 milligrams t.i.d. These took the form of cogwheel rigidity, facial manifestations, drooling and thick speech. In addition, four patients developed unilateral tremors in the upper and lower extremities, two on the right and two on the left.

When medication was discontinued, most of the extra-pryamidal symptoms disappeared, but the unilateral tremors lingered from three to four weeks.

Another unusual manifestation of parkinsonism that was not seen with other ataractics than vesprin was the bouncing motion of the patient on the balls of the feet—another manifestation of dyskinesia. It should be noted that these patients were receiving the ataractic drugs for the first time.

Representative Case Report

R. M., a 38-year-old, white man, hospitalized continuously since 1936, was placed on vesprin July 17, 1957. He received 10 milligrams daily for 10 days. On July 27, the vesprin was increased until he was receiving 50 milligrams, t.i.d., by August 2. On August 10, the patient developed secondary extrapyramidal symptoms with cogwheel rigidity bilaterally, and unilateral tremor of the upper and lower left extremities. On September 9, the vesprin was reduced to 25 milligrams, b.i.d., and subsequently was discontinued. Not until September 30, did the unilateral tremor disappear. While manifesting other extrapyramidal symptoms, this patient also developed a peculiar bouncing up and down on the balls of his feet, indicative of another form of dyskinesia.

Pilgrim State Hospital
West Brentwood, N. Y.

EDITORIAL COMMENT

THE SUICIDAL ANIMAL

There is an ancient "canon 'gainst self-slaughter." But there is an also ancient path man has traveled since time immemorial when he found life unbearable. There have always been those who have not agreed with the pessimistic Preacher of Ecclesiastes that "a living dog is better than a dead lion." And rather than be a living dog . . . ! There has always been, canon or no, the way of self-slaughter.

Man has been variously, and sometimes cleverly, defined by philosophers, satirists, economists, anthropologists, theologians. Man is the intellectual animal, the creature with the capacity for abstract thought and pure reason. He is the talking animal, the mathematical animal, the social animal, the economic animal, and, as the General Semanticists put it, the "time-binding" animal. He is the creature with an immortal soul—or he is the immortal soul himself. One of the most apt of the definitions is that man is the cooking animal—no other makes or uses fire, or prepares his food by it.

It should also be observed that man is the suicidal animal. Man is the only creature known to man who purposively and with aforethought ever puts an end to his own existence. Other creatures have been known to starve themselves to death in captivity or grief, or to injure themselves fatally in what looked like deliberate action; but there is no reason to believe that they consciously sought death. Suicide is as much a mark of humanity as language, fire or the invention of the wheel. The ant may wage war, the bull or the tiger may commit what we consider murder, the wolf may be a cannibal. But it took man to devise the ultimate violence against himself. With human intelligence, came the overdevelopment of human emotion and the ability for introspection. With human emotion and human introspection, came suicide.

The first suicide must have come long before that other primal crime, the killing of the tyrant old man and the totem feast on him. The first suicide must have come when man first developed enough foresight to seek flight from the suffering of impending disaster or tragedy. It likely came before language, possibly be-

fore tools and fire, certainly before humans had banded into anything more than an animal form of society.

In all the millennia, we have learned little more about the why's and wherefore's of this violent way of ending life than we know about life's creation or beginning. In some ancient cultures and at least one modern society, suicide has been a work of honor, to be undertaken solemnly and thoughtfully, by sane men, under specific and socially-recognized circumstances. Even in the modern western world, we have one conspicuous and time-hallowed circumstance under which suicide was long considered admirable—the tradition that the captain should go down with his ship. Action amounting to suicide was long demanded by "honor" from the unskilled citizen challenged by expert swordsman or crack pistol shot to a duel. And the leading of a "forlorn hope" has always been an honored form of military suicide.

But to put it in the mildest terms that one can, suicide in our world is now generally socially unacceptable. Furthermore, it is recognized in nearly all cases as a socially unacceptable act of the sort that is associated with mental disorder. It is, many more than nine times out of 10, convenient to consider it a symptom of mental disorder. Or, perhaps better, it is the terminus of several mental disorders. There has been considerable debate of late, as there generally is whenever a new treatment method becomes popular or a new theory becomes the subject of wide discussion—as to whether it is entirely proper to talk of any mental disorder in the same terms as a physical disease. Nobody in this day doubts that mental trouble is a medical problem, but can hallucination or delusion as a symptom be related to schizophrenia as an elevated temperature is to pneumonia, or as a high white corpuscle count is to appendicitis? If this is loose usage, confusing sign and symptom, just what are physical symptoms anyway? And if, in mental disorder, there are undoubted relationships between disorder and what we call symptom, just what are they? In mental disorder, we cannot always be sure which is primary—what we call the symptom, or what we call the disease. If suicide is a symptom, as it is generally considered, there are also signs that it is primary in nature.

The trend toward self-destruction is probably older than the human self. Most psychiatrists, psychoanalysts and psychologists

now accept the existence of the death instinct—Thanatos. Its workings appear to be observed in other creatures than man—although other creatures than man do not commit suicide, which is not only a seeking of death, but an aware and purposeful seeking. If an animal, which manifests the death instinct, brings about its death by starving itself, it is impelled by instinct toward an end it does not recognize or understand. Its death follows the dictates of the instinct. If a human brings about his own death by starving himself, he is proceeding toward a goal he does understand. His death may be impelled by instinct, but it follows a conscious wish or an impulse to terminate his existence. He has a definite purpose, whereas the starving animal merely is obeying blindly a sustained and powerful drive. If the death instinct, the ultimate aggression against the self, is older than man, its conscious recognition and deliberate satisfaction are purely human.

But if suicide is, even in part, dictated by an instinct, can it be a sign or symptom of disease? One approaches there the fundamental difficulty in acceptance of a death instinct: Can an instinct be morbid, or unhealthful, or destructive in nature? Instinct in general is directed toward the preservation of the individual and the propagation of the species. Can it also be aimed toward individual extinction? The evidence appears to be that it can be.

As physical health represents a condition of homeostasis—or, loosely, balance—among normal bodily states, so mental health may be thought of as psychic homeostasis. In this homeostasis of mental health, Eros holds Thanatos in check; libido blocks destrudo; the vigor of life prevails over the forces of death. With wavering homeostasis in mental ill health, Thanatos summons his powers; destrudo of redoubled force strikes weakened libido; and the death wish may prevail. The conflict is one of primeval forces; it is a struggle deep within—between elemental drives. In suicide, is one of the ultimate triumphs of Thanatos and his allies—for Thanatos has allies, other powerful forces than instinct to urge dissolution. Here the question arises again whether self-destruction after so desperate and fundamental a struggle can logically be discussed—as it has been discussed here—as a symptom, or as anything else secondary to a mental or other disorder.

Suicide has another characteristic to differentiate it from ordinary signs and symptoms. It is contagious (or infectious if one

prefers). A disease may be contagious; its signs are never contagious; its symptoms are not ordinarily contagious. One contracts smallpox from contact with the smallpox virus, not from the symptomatic pock marks; typhoid is spread by the bacillus, not by the fever; poliomyelitis is disseminated by its virus, not by the crippling and the destruction of nerve tissue which are among its symptoms. Only in the mental syndromes, are symptoms contagious. In *folie à deux*, the recipient may contract a whole delusional system from an instigator, complete with hallucinations. In the psychosomatic diseases and conversion hysteria, there may be apparent contagion of allergies, gastric spasms, headaches, visual disturbances or paralyses, that is, of symptoms. Suicidal trends and suicide perhaps belong with these contagious "symptoms." Or perhaps we need another word than symptom—some new term altogether— to distinguish the concept of a mental or emotional syndrome from its clinical manifestations. For we may reach a point—as with suicide—where it is difficult to determine which is primary, the phenomenon we customarily call the symptom, or the syndrome in its background. In some aspects, suicide may be a symptom; but suicide is also an aspect of death, a form of death. As a form of death, suicide presents an aspect in which it is definitely not a symptom.

These notes are preliminary to discussion of suicide in its social and mental hygiene setting. They are set down as illustrative of the confusion in which one can get in attempting to discuss it merely in its psychiatric setting. Sorted from the confusion is at least one certainty, which fortunately is the most important consideration when suicide is discussed in its varying interpersonal implications. That most important consideration is, as has been said, that suicide—whether a symptom, a terminus or a disorder in itself—is highly contagious. This is not, of course, its only social or interpersonal aspect. There are moral and religious aspects, for example, both of which involve social and interpersonal considerations.

If a very few of the psychiatric aspects of suicide have been touched upon here, the purpose is to suggest that, by discussing such matters in public, the social and mental hygiene considerations of the problem have been complicated needlessly. The dynamics of suicide are still highly debatable. Identification of one

sort or another certainly plays a part. The death instinct may be operative. However one names it, introjected hostility has a decisive role—hostility against the parent, perhaps in the form of the super-ego. "In killing me, I kill my enemy; and I satisfy besides the instinct to reduce organic matter to inorganic inertness and equilibrium." But these matters and many others are purely psychiatric and psychoanalytic considerations. Furthermore, they are distinctly clinical affairs; they either involve direct clinical observation, or they are theory based on clinical observation; the data psychiatry alone provides do not lend themselves to easy arrangement, tabulation or statistical analysis.

In dealing with suicide outside its psychiatric setting—in the social field where public health and mental hygiene considerations are paramount—there are data which do lend themselves to arrangement, tabulation and analysis, but not for psychiatric purposes. The laws of virtually all civilized societies require the reporting and recording of suicides, along with other forms of death of importance to the public welfare. A beginning, at least, has been made, toward studying the epidemiology of suicide—even though it might appear to the psychiatrist that such a study would be comparable to the epidemiology of sore throats or stomach aches. All literate persons are presumably aware that such studies as have been made show a relationship between suicide rates and economic and social conditions—as is the case with other mental disturbances. They also strongly support the clinical observation that suicide is infectious.

The incidence of suicide, its cash cost, its weight in grief, and the burden it leaves in twisted and shattered lives of survivors are all things we tend to underestimate. Like other unpleasant truths, they are things we do not willingly face. In the case of suicide, the unpleasant truth—in public health terms—is that it is endemic; add, for any reason, a factor of virulence, and it can rapidly become epidemic, as it did in Germany and Austria shortly after World War I. Suicide, observes Dr. Howard A. Rusk,* is "usually" among the first 10 causes of death in this country. It has just missed the first 10 in the last three years for which statistics are available; the rates were: 10.1 per 100,000 in 1954 and

*New York Times, May 19, 1957.

1955, and were estimated at 9.9 in 1956*; but the figures are high enough in all conscience; they place suicide in the group of the worst killers.

The epidemiology of suicide is confused, Dr. Rusk points out. There have been studies attempting to relate it to weather, season and religion. But the incidence of suicides in the United States and Australia is higher in spring and summer months of pleasant weather than in the dark, gloomy days of winter. Correlation with religion is inconsistent. The Roman Catholic Church takes a very stern view of suicide, Dr. Rusk points out, and the suicide rate in Catholic Ireland is low, as might be expected. But the suicide rate in Protestant Scotland is low, and that in Catholic Austria is high. Dr. Rusk does not make note of it; but Austria was the center of a suicide epidemic, triggered by a gloomy popular song, about a generation ago.

Dr. Rusk notes among facts about suicide that the frequency among clergymen is low, as is to be expected. But, curiously, that among soldiers is high; perhaps an unconscious mechanism in choice of occupation would explain it. Teachers have a low suicide rate, physicians a high one. Men suicides outnumber women three to one. The whole subject calls for more research; as Dr. Rusk remarks, a great deal needs to be done "on the most important question of all—why?" One of the few general facts we are sure of in answer to "why?" is that the answer can be another earlier suicide. One suicide can cause others the way one case of varicella can start a run through an orphan asylum.

The precise extent to which suicide is contagious is another and a difficult problem. St. Peter and his opposite number in Sheol have the only opportunity one can readily imagine of getting first-hand information by questioning successful suicides on their motivation. The extent of contagion can otherwise be judged only from observation (not analysis) of the statistics during periods when suicide is epidemic; from clinical observations at times when one suicide attempt follows another on mental hospital wards; and from such indications as that a parent who commits suicide is likely to leave children who seek the same solution to their difficulties many years later. From all these indications of which not

*Encyclopedia Britannica: Britannica Book of the Year. 1957.

one is subject to precise analytic study, the reasonable conclusion is that the degree of contagion in suicide is very high indeed.

Combining what we know about suicide from clinical observation and theoretical psychiatric study, with what we know from public records, there are several apparent points of attack where psychiatry might well operate to reduce the burden of suicide more effectively than it has been doing. To make the first, the link of suicide to mental disorder is undoubted—whatever its nature—and appreciation of this fact is less wide than it should be. Statistics, of course, are unobtainable as to the mental states of the vast majority of suicides and attempted suicides. The cases that can be studied—hospitalized attempted suicides—reveal a wide variety of abnormal mental conditions. This journal has published a number of studies from several hospital and other psychiatric sources; and it is the utmost in understatement to say that they all point to abnormal mental processes.*

Somewhat wider understanding of this fact might operate toward alleviating guilt, or even toward making grief more bearable among survivors. It should be said that this does not amount to a certificate of "insanity" for all suicides. There are instances where people, who are normal as far as psychiatry can tell, commit suicide to avoid the pain and expense of prolonged and hopeless illness. There have been many instances in the past and are doubtless some in the totalitarian lands of the present where normal persons resort to suicide to escape torture or to escape the danger of betraying friends and principles under torture. But these are instances of the highly exceptional. So is the suicide for justifiable fear of the pain and expense of illness highly exceptional. The physically ill person who commits suicide ordinarily is in an abnormal mental state in addition. The person who commits suicide for fear of "disgrace" or because of "money troubles" is al-

*Bergler, E.: Problems of suicide. PSYCHIAT. QUART., 20:2, 261-275, April 1956.

Broida, D. C.: An investigation of certain psychodiagnostic indications of suicidal tendencies and depression in mental hospital patients. PSYCHIAT. QUART., 28:3, 453-464, July 1954.

Hendin, H.: Attempted suicide: a psychiatric and statistical study. PSYCHIAT. QUART., 24:1, 39-46, January 1950.

Oberndorf, C. P.: Study of a case of suicidal flight. PSYCHIAT. QUART. SUPPL., 24:1, 11-22, 1950.

Schreiber, H., and White, M. A.: Diagnosing "suicidal risks" on the Rorschach. PSYCHIAT. QUART. SUPPL., 26:2, 161-189, 1952.

most invariably in some degree of mental derangement—a matter which requires very little proof beyond the notation that the result of the suicide is generally much worse than the result of the anticipated troubles, something that would have been apparent immediately to anybody whose mind was functioning normally.

A little more general diffusion of the knowledge that suicide is not commonly performed by a person in a normal mental state might lead to much alleviation of grief, remorse and despair on the part of relatives. It might also lead to more general appreciation of the fact that there are practical steps which can be taken to lessen the incidence of suicides. There would be fewer, for example, if there were more general appreciation of the fact that irrational depression may be a danger sign, and that talk of committing suicide is not to be taken lightly.

One hears fairly often, for example, expressions of the mistaken, and apparently common, belief that a person who talks of killing himself is in no danger of doing it. Along with the belief that a person is or is not "a suicide type," which the ordinary observer is expected to recognize by intuition, the idea that a person who talks of suicide will "take it all out in talk" is one of the most important factors in creating negligence around a suicidal person, where precaution is needed. Two of the several matters which have been thoroughly demonstrated in the clinical study of suicide are that there is no such thing as a "suicidal type" (suicide occurs in all types), and most persons who attempt suicide or succeed in it have talked about it beforehand. That any sort of person may commit suicide, and that talk of committing suicide is a danger signal are matters which ought to belong in any general program for education in mental hygiene.

The still more important clinical observation that suicide is infectious brings up another and far more difficult problem in mental hygiene and public responsibility. If suicide is contagious, one is likely to be followed by another in the neighborhood, the city or the surrounding community. A spectacular suicide of an important person is likely to lead to large numbers of suicides and suicide attempts. What ought to be done about this and what can be done about this are different problems—and separate ones. The psychiatrist's first natural reaction is: Don't publicize suicide—don't say publicly that this death or that is a suicide; and don't

publish the fact. Whether this is a good idea is something to be discussed on its own merits; whether it is possible, if it is a good idea, is a problem with different aspects.

Suppose it is possible not to publicize suicide; suppose it is possible to make death by suicide as much a private matter as death from pneumonia or cerebral hemorrhage! Suppose a campaign with this objective to be completely successful! One can see that no formal notice is taken of suicide, but one cannot suppress whisper of suicide or rumor of suicide. For the reader who cannot think of an actual instance, here is one from the New York metropolitan area in the 1930's. A woman well known in her community died suddenly. Her death was not reported as suicide, and she was cremated after conventional funeral services. Then her small daughter told the neighbors, "Mama drank a can of lye." Daughter's imagination may have been working overtime—with what unconscious motivation the psychiatrist is at liberty to guess—but there is suicide, unpublicized, perhaps not a fact at all, but as contagious as if it had been announced by the town crier.

For a case which many of us can recall, there is the death of Warren Gamaliel Harding.* President Harding died suddenly while apparently convalescing from pneumonia, but under circumtances in which any physician would consider death not entirely unexpected. Had he lived, he would have had to face—as soon became evident—a horrifying scandal in his cabinet, and possible personal impeachment and disgrace. Therefore, almost certainly baseless rumor started that he had committed suicide to escape threatened disgrace, or, alternatively, that he had been murdered in an effort to protect his own reputation and the standing of his cabinet associates. There was no autopsy to afford disproof. If Harding, in the face of convincing evidence to the contrary, did, in fact, commit suicide, it was not publicized—it was a suicide in which for 35 years there has been no public admission of the fact. But this unadmitted suicide—which almost certainly did not occur—was trumpeted from one end of the land to the other, with as unfortunate effects as if the newspapers had screamed "suicide" in daily headlines.

So much for the impossibility of suppressing whispers and

*Thornton, Willis: Fable, Fact and History. Greenberg: Publisher. New York. 1957.

rumors of suicide. The question would still remain whether less emotional damage is done to susceptible persons—and the public at large—by this sort of thing than by forthright publication. There is some reason to think it is less, for fewer persons are likely to hear the widespread rumor than would read the printed account. Any mental hospital director can testify to the difference in emotional tone and in danger to his patients between the suicide known only to a handful and the one known all over the hospital. No doubt most psychiatrists would conclude that the fewer persons who know about a suicide, the better.

All this is from the medical, specifically psychiatric, view of the public welfare. There is another view in which psychiatrists are interested as citizens, as well as professional people. That is the worth of the general policy, the good or the evil, the morality or the immorality, of seeing that the public knows the truth. The promise of Jesus,* "And ye shall know the truth, and the truth shall make you free," has long been accepted as good religion and is now generally accepted as good mental hygiene. Should we now consider it good mental hygiene as applied to all truth—or only to some of the truth? The scientist can point to precedent, in general secrecy about the sources and potency of common poisons, and in the restriction of medical literature to professional readers, for excepting certain types of information from the truth one tells to all. And every citizen knows there is classified information—unpublished truths, in the realm of national defense—the publication of which would be far from good sense, or good mental hygiene either. Suicide is not a defense problem, but a good case could be made out for including data about it among the medical information which the public would be better off without. One can, however, admit freely the right of the public to full and free information on a subject, and at the same time make the sound contention that information of this sort should be presented unemotionally, and made public without sensationalism. Cancer morbidity and mortality statistics are handled in this fashion, so, generally, are the hysterics-laden data of civil defense and possible atomic warfare.

If this sort of presentation is, in fact, desirable, the problem is one of education and self-restraint on the part of those who

*John 8. 32.

discuss, or write of, suicide. It is not a problem of prohibition by law, for it runs with a crash headlong into constitutional guarantees of freedom of speech and of the press. Even if there were no constitutional protection of these freedoms, psychiatry would need to think more than once and more than twice before proposing prohibition of news of suicide—or of any other sort of news whatever. The cutting off of legitimate channels of information always sets up illegitimate channels of misinformation. Natural deaths (Harding's—and perhaps the story of "mama" and the can of lye) are whispered about as suicides; tales are magnified and distorted as they are passed on. Actual suicides are whispered about as murder; more important, there is constant suspicion that murder is going unreported and undetected under the guise of unreported suicide.

The problem of news reports of actual suicides is, of course, not the only one involved in the epidemiology of suicide. There is the question of fictional suicide, particularly as presented in drama through such mass media as motion pictures, television and radio. A voluntary censorship which proceeds to "Nice Nellie" extremes largely eliminates suicide as a movie problem. Both television and radio have exercised rather intelligent restraint. Suicide is a fact of life (or death), and nobody expects serious writers —whether of drama, poetry or the novel—to ignore it. And nobody wants them to.

Walter Hawver, television columnist for the Albany (N. Y.) *Knickerbocker News* and other newspapers, made some comment not so long ago which is worth noting here.* It concerned the recent television presentation of John Galsworthy's play, *The First and the Last*. "The denouement of this play," remarks Mr. Hawver, "pictures a murderer and his sweetheart taking their own lives." The play is adult entertainment; suicide has a legitimate role in adult entertainment. It appears in the ancient dramatists, in Shakespeare's plays and other classics of the English-speaking stage, and in modern drama ranging from the Galsworthy effort discussed here to the famous play based on Somerset Maugham's short story of the missionary and the prostitute, *Rain*. Suicide has appeared in radio and television dramatizations of police

*Column of July 17, 1957.

work and in such plays as that astonishingly adult Western series, "Gunsmoke."

The television and radio codes concerning suicide, Mr. Hawver brings out, do not attempt to prohibit the presentation of suicide themes over the air. They do, however, prohibit the presentation of suicide "as an acceptable solution for human problems." With that, one thinks, the classic dramatists and the modern psychiatrists would have been in agreement. Suicide is sometimes the obvious, sometimes the inevitable, solution for a dramatic impasse; but it is always a regrettable one. Its presentation is not the sort of thing to set off epidemics in imitation. Suicide in a bare news report may appear to solve satisfactorily some unknown's problem—and so suggest suicide as a satisfactory solution of other problems. But, presented with its motivation and its inevitable tragedy, suicide in the adult drama has fewer attractions. By the nature of modern tragic drama, suicide—however inevitable—is never heroic; it bears its own burden of sordidness and tragedy; it is nothing to emulate. And the radio and television policies for its presentation seem altogether admirable.

Psychiatry cannot reasonably blame the press, the radio or other media of public information for resisting restraints on free speech and a free press. For one thing, psychiatry itself has a stake in free expression. If freedom of publication ends, scientific freedom also ends. A Pavlov-minded psychiatric authority could suppress Freudian teaching and experimentation—as has actually been done in Russia. A Jungian board of control could prohibit experimenting and reporting in drug therapy. In fact, any sort of psychiatric fanatic could suppress all the rest of us.

This sort of special interest aside, psychiatry, of all the scientific disciplines, has the strongest reason to know what lethal effects the suppression of full and free information can have on a democracy. Thus, this is no spot for psychiatry to sit down and wail that there "ought to be a law about it." There ought not to be a law about it. But there ought to be a recognized way of handling the news of suicide, which would come nearer than present practice to recognizing and guarding against the danger of contagion.

There is general practice now which takes account of the dangers in particular types of news reports. Because of both suicide

and murder, responsible newspapers have refrained for many years from publishing the names of poisons in violent deaths or from indicating where such poisons may be obtained. There are other well-recognized restraints, some to protect the public, some to protect the newspapers themselves, in the publication of police news. In New York State, there is an unfailing source of sordid "sex crime" news in trials of second-degree rape cases. These cases are not instances of rape by force, but of sexual intercourse involving girls under the legal age of consent. There is nothing to prevent reporting such cases in sordid detail (if the names of children are withheld): but unless there is some very unusual feature, no respectable newspaper ever reports one. This abstinence is in the interests of what can only be described as professional journalistic responsibility toward "the young rape victims" and toward the public.

Similarly, only the tabloids practise sensational treatment of sex murders and other major sex crimes. Sex crime, like suicide, is infectious; but, unlike the case of suicide, the responsible newspapers recognize the fact. Their dilemma is, of course, distressing —whether to leave the public in ignorance of a menace, or, by publicizing it, to hazard precipitating more sex crimes by deranged, predisposed persons. The generally-accepted, conservative solution is to report any such crime, unless both local and unusual, in unsensational language—with unsensational headline and make-up treatment. Nobody pretends this is an ideal solution, but it is a practical, workable one. It deprives the responsible newspapers of many "legitimate," sensational, circulation-building stories; but it is a voluntary deprivation in the public interest.

What is now suggested here is that, because of the contagion of suicide, the working out of some standard method of unsensational reporting would do no harm to the newspapers and would serve the public interest. Nobody is going to argue against the reasonable newspaper point of view that news is news. If Mao-Tse-tung takes rat poison, if Gina Lollabrigida does a hop, skip and jump into Vesuvius, or even if the comparatively obscure mayor of the city dives head-first from the roof of city hall, nobody in his senses would expect even a conservative newspaper to refrain from plastering its front page with big type. Or, there was once a newspaper classic, presumably fiction, of a man who wanted

to make a thorough job of his exit. He booked an overnight trip on an old-fashioned paddlewheel steamer, waited until it was dark, went to the stern, drank poison, stood on the taffrail, shot himself through the head, and fell into the paddlewheel. Be it infectious or contagious or not, nobody would expect a newspaper to neglect that sort of story either.

But more restraint than is usually exercised might be good public policy in the case of the ordinary citizen who takes too many sleeping pills, resorts to the attic with a rope, or starts his last long sleep in his automobile in a closed garage with the motor running. These are not extraordinary occurrences. They are not far removed from natural death under certain conditions: That is, they are the logical consequences of some forms of mental disorder when there is no proper medical treatment—or when treatment fails. Medically, there is an almost perfect analogy between the untreated depressive who hangs himself and the untreated victim of diabetes who dies of that disorder.

Many psychiatrists feel strongly that public welfare would be served best by simply reporting such events as "died suddenly." Even if they are right, the newspaper will never surrender its point of view that "died suddenly" is far less than the performance of its own duty to the public. "Died suddenly" will not satisfy a neighborhood—or even a town or a city—seething with rumors and wondering what horrendous thing has happened, or what monstrous crime is being concealed. But "died suddenly" can be amplified without sensationalism. That the sudden death should be ascribed to an overdose of hypnotics or to carbon monoxide poisoning in kitchen or garage could follow—not unnaturally. Traditionally, one does not refer to gun, knife or rope in a formal report of a death—that is, in an obituary notice. And the words "died suddenly" would automatically make a news report of an ordinary unsensational suicide into an obituary notice. But the problem should not be beyond the capacity of journalistic ingenuity, even if a new tradition must be established to replace the old.

The solution discussed is one of those compromises which will satisfy no one. The psychiatrist will be unhappy that suicides are still being reported, with continued contagion. The newspaper will be unhappy at the loss of "dull day" headlines, and unhappy in the feeling that perhaps it is neglecting a public duty in de-

liberately subordinating a class of news about which the public is entitled to information. But the danger of infection can be materially lessened; and the sense of realized public responsibility should eventually outweigh the guilt of imagined neglect.

It is an interesting and unusual problem when the ethics and practices of two professions, both charged with duty to the public, are in apparent conflict. The fight for freedom of speech is probably as old as the medicine man's struggle for scientific freedom. It was quite as important for the development of culture that the young warrior should be permitted to raise his voice in council against a stupid military policy, as it was for the "doctor" to establish his right to insist on dried toad in his medical brew, in the face of the chief's order to use dried frog instead. Both medical freedom and freedom of speech have had their martyrs. Freud was derided, Paré abused, Semmelweis disgraced. But pamphleteers were jailed, fighters for a free press mobbed, and protestants against civil and religious tyranny imprisoned, assassinated and burned at the stake.

Scientific freedom is beyond price; so is freedom to write and speak. (In fact, without freedom to write and speak, scientific freedom is worthless—as Roger Bacon and many another could testify.) But voluntary restraint in the selection and presentation of news is no restriction on anybody's freedom. What the psychiatrist can work for and hope for in the way of voluntary self-restraint is the handling of news of suicide in somewhat the way that responsible newspapers now handle the news of sex crime. This means that the psychiatrist must take the initiative—personally or through mental hygiene organizations—in approaching his local newspapers and urging a policy of news handling that will accord better with public health needs. No journalist would knowingly circulate a newspaper that had been soaked in anthrax or typhoid bacilli. No journalist will willingly circulate a newspaper calculated to spread the infection of suicide—though he will find the problem more complicated here than it appears to the psychiatrist.

It should, nevertheless, be possible to work out an approach to a code of ethics in reporting suicides that will lessen what the psychiatrist sees as the danger of contagion. The approach to such a code will be through individual newspapers and professional in-

dividuals and groups. There will be trial and error, with many local differences in attitude and handling, before any general code can be worked out. But a general code should be sought—for the problem is not growing any less acute, but is becoming more serious day by day. A recent review of suicide among children and young people reports it fifth in frequency as a cause of death among adolescents from 15 to 19, and notes that it has been the second most frequent cause of death among students at Yale for more than 20 years, accounting for 12 per cent of all student deaths there from 1925 through 1955.*

It seems apparent that we have been mishandling for many years a public health problem of the first magnitude.

*Bakwin, Harry: Suicide in children and adolescents. J. Pediat., June 1957.

BOOK REVIEWS

The Life and Work of Sigmund Freud. Volume 3. The Last Phase. 1919-1939. By ERNEST JONES, M.D. 537 pages. Cloth. Basic Books. New York. 1957. Price $7.50; $21.00 per three-volume set.

With a volume devoted to the years from 1919 to 1939, Ernest Jones completes his definitive biography of Freud. The years from 1919 to 1939 were the years of Freud's fame and recognition and of his mental and physical suffering. An appendix includes the surgical notes, made over a period of 16 years, on the throat malignancy which finally led to Freud's death. The final volume covers the dissensions of Rank and Ferenczi, years of successful practice in Vienna which followed the world-wide recognition of Freud's contribution to medicine, his exile, illness and death in London. It is well known that Freud continued his practice as long as he was physically able to and that he went on with his research and his other professional activities until almost the very end.

Four days before his death he sent for Ernest Jones to say goodbye to him, opened his eyes, waved his hand to him and then returned to sleep. Although Freud was a co-discoverer of cocaine, he shared the dislike of many good doctors for narcotics and asked for sedation only after long suffering and only two days before his death.

The ill-founded criticism has been made, principally by lay reveiwers, that Jones has been compiling a rather worshipful account of Freud's work and life. To the contrary, this third volume adds to the evidence of objectivity. Freud, as Jones saw him, was far from the perfect man or the perfectly adjusted man, and where the author feels that Freud acted emotionally or irrationally, he does not hesitate to say so.

Besides the biographical account of Freud's last 20 years, this third volume includes nearly 200 pages of discussion of Freud's scientific accomplishments in that period: in clinical psychoanalysis, in metapsychology, in biology and anthropology. A critical comment of considerable interest is Jones' observation that Freud "never gave up a jot of his belief in the inheritance of acquired characteristics." (It would have been interesting if he could have lived to comment on Lysenko.) Jones relates that he had begged Freud to alter a sentence in his book on Moses in which Freud expressed the Lamarckian view that acquired characteristics could be inherited. Jones remarked that no responsible biologist regarded this position as tenable any longer. But: "all he would say was that they were all wrong and the passage must stay." Jones also reviews Freud's contributions to anthropology and sociology and his attitude toward re-

ligion and occultism. He excuses himself from "discussing the vast theme of Freud's influence on literature in general, a task far beyond my powers."

The three volumes of Freud's life are subject, of course, to criticism by other associates and students of the founder of psychoanalysis, but it is hardly conceivable that a better biography can ever be written. *The Life and Work of Sigmund Freud* is, of course, indispensable in any scientific, psychiatric, psychological or sociological library.

The Great Physiodynamic Therapies in Psychiatry. An historical appraisal. ARTHUR M. SACKLER, M.D., MORTIMER D. SACKLER, M.D., RAYMOND R. SACKLER, M.D. and FELIX MARTI-IBANEZ, M.D., editors. 190 pages. Cloth. Harper. New York. 1956. Price $5.75.

The editors present in their foreword and in the first chapter of this work a bird's-eye view of "physiodynamic" therapies, their historical background and their value in psychiatry. In the first chapter, entitled "The Philosophy of Organicism in Psychiatry," they report on historic organicism, note its present status and forecast its standing in future psychiatry. In the last chapter of the book (Chapter 8): "Contemporary Physiodynamic Therapeutic Trends in Psychiatry," they lay stress on present-day research and express the viewpoint that physical and biochemical etiologies are going to outweigh the dynamics of a psychological nature in modern psychiatry.

The remaining six chapters comprise contributions by the originators and pioneers of physiodynamic therapies. Dr. Manfred J. Sakel names his chapter: "The Classical Sakel Shock Treatment." He pleads for what he considers the correct, and successful, application of insulin shock therapy. Dr. Laszlo Joseph Meduna appraises and reappraises metrazol convulsive treatment. Dr. Ugo Cerletti describes the history and therapeutic application of electric shock treatment. Dr. Egas Moniz heads his chapter: "How I Succeeded in Performing the Prefrontal Leukotomy." Dr. Roy G. Hoskins discusses physiology and the application of hormone therapy. Dr. Meduna, in Chapter 7, presents a review of carbon dioxide therapy.

The book has an extensive bibliography and has in addition biographies of Drs. Cerletti, Hoskins, Meduna, Moniz and Sakel.

The Great Physiodynamic Therapies in Psychiatry contains a wealth of information and should be read by everyone professionally concerned with the problems of mental illness. Many psychiatrists may not agree with the theoretical and therapeutic claims of the editors and authors, especially since they are, in part, presented in dogmatic and polemic fashion. Any psychiatrist may find in this book a good orientation in the evolutional and clinical know-how of physiodynamic therapies.

Mushrooms, Russia and History. Two volumes. By VALENTINA PAVLOVNA WASSON and R. GORDON WASSON. 433 pages including illustrations, indices and appendices. Cloth, 9¾"x13". Pantheon. New York. 1957. Price $125.00.

This is a review of a loaned book which readers will be unable to buy—a violation of several of this journal's strict, if unwritten, rules for reviewing. (Books not received for review and not available for purchase are not, as a rule, reviewed anywhere by anybody.) This book, borrowed from the authors, is reviewed as an exception because it is a most unusual work, of considerable cultural and scientific interest.

The authors are a New York woman physician, who was Russian-born in the days of the czars and is a mycophile, and her husband, who is now a banker and has been a professional writer. Although they describe themselves as amateurs, writing for connoisseurs, there is nothing amateurish about their production. It started, Dr. Wasson explains, as a footnote to what was intended to be a book dealing with Russian life and Russian cooking. The subject ran away with them and bolted all over the world, through Russia, the Basque country, the Arctic, England, ancient Rome, the United States, Siberia, Mexico and Central America.

The mushroom has its place at the epicure's table, in the poisoner's cup, in mythology and folklore and in religious ceremonials. From wandering in Russia on a children's mushroom-picking expedition, the authors have pursued a trail like that followed in Frazer's *Golden Bough*. They have come up with a new explanation of the murder by Agrippina of the Roman emperor Claudius—with an assist here by Robert Graves. They have traced the toad, through its connection with "toadstool," through a venomous course all over Europe. Toad venom, Dr. Wasson explains, is not mere superstition; the toad actually excretes a poisonous substance when irritated. From this medical note, one may trace mushroom and associated toad through devious channels of folklore and superstition. The authors recognize the phallic significance of the mushroom and its apparent connections with ancient rites and mysteries.

There is a tremendous amount of research and erudition here, one custom leading to another, one incident to cognates in other lands and other languages. R. Gordon Wasson, the co-author, is largely responsible for this and he is responsible too for a large section of Volume II, dealing with personal participation in religious mushroom ceremonies in Mexico. (An Aztec oracle of Delphi?) There are careful subjective descriptions of hallucinations and related experiences here, and this part of the work is of particular concern to psychiatrists interested in experimental hallucinations and in other hallucinations deliberately produced as social phenomena. There is also, of course, material of great interest in the psy-

chodynamics of mushroom lore and in other accounts of the use of mushrooms for purposes of intoxication. There is an extensive bibliography in the form of footnotes.

These volumes are magnificently illustrated. There are plates of the beautiful watercolors of Jean-Henri Fabre and of numerous other appropriate subjects, many in color, some in black and white, 72 in all, besides text illustrations. The watercolors were reproduced by a delicate collotype process which gives splendid illustrations but is not rugged enough for mass reproduction. Only 512 copies of this book—beautifully printed in Italy on hand-made paper—were published; the issue was soon exhausted; and there are no plates. There is, therefore, no hope of a large, less expensive edition; and interested persons in New York are advised that they may consult or study the work at the New York Academy of Medicine, the New York Botanical Garden, the Metropolitan Museum, the Museum of Natural History, the National Audobon Society library and the New York Public Library. For others, the reviewer can only hope that some scientific or general publisher will discover that the text, even without the plates or with substitute illustrations, is worth reprinting. It is far too good a work to leave in this small collectors' edition.

The Dissociation of a Personality. By MORTON PRINCE, M.D. 575 pages including index. Cloth. Longmans, Green. New York. 1957. Price $5.00.

The Dissociation of a Personality is the re-issue of one of the classics of abnormal psychology. First printed in 1905, it appeared in a second edition in 1906 and was thereupon reprinted seven times up to 1930. The present issue is the first reprinting since that time.

As is very well known, Prince's Miss Beauchamp is the classic case of multiple personality in a hysteric. It has been studied and re-studied. It lacks, of course, the foundation which dynamic psychiatry has acquired in the last half-century, but the treatment is in many respects astonishingly modern. This book is one that belongs in every psychiatrist's library and in every library of medical history.

The Strong Hand. By MICHAEL BLANKFORT. 317 pages. Cloth. Little, Brown. Boston. 1956. Price $3.75.

This is a novel about the conflict between Jewish tradition and the realities of modern life. A young rabbi falls in love with a woman whose husband was presumably killed as a flier during the war. According to Jewish religious law, there must be a witness who testifies to having seen the body, otherwise the marriage is considered adulterous. The author depicts the conflict of the lovers sympathetically; old customs are not attacked, but glorified. The weakest part of the book is the lack of psychological elaboration of the realistic conflict.

In the University Tradition. By A. Whitney Griswold. 161 pages. Cloth. Yale University Press. New Haven. 1957. Price $3.00.

The president of Yale University presents, in a series of short addresses, essays and commentaries, notes on the educational and social value of conversation, on college athletics, on the advantages of a residential college, on universal education, on general and academic freedom and on the value, for freedom and for life, of study of the liberal arts. He stresses the worth of the liberal arts in safeguarding freedom; and he emphasizes the role he feels they should play in preparation for specialization. A scientist or engineer or other professional man, he feels, should have sound grounding in the liberal arts before he undertakes his specialized training. He quotes with approval a proposal providing for universal education in the primary grades and education at public expense through the university level: by free primary schools, the selection of their best pupils for free secondary schools, and the selection of these secondary schools' best pupils for university training. This is not a modern left-wing proposal but was urged by Thomas Jefferson as a means of seeking out "worth and genius . . . from every condition of life . . . completely prepared by education for defeating the competition of wealth and birth for public trusts."

In the University Tradition is a small volume solid with worth. It is written in the tradition of freedom, in the sound belief that the principles of thought and judgment derived from a liberal arts education are the best safeguards of freedom. The liberal arts, the contention is, form the basis for habits of reasoning and of orderly thought, and for the means of evaluating our society and its achievements. "We profess dismay," says Griswold, "at the number of our acquaintances swallowing tranquilizers and rushing off to psychiatrists to make up their minds for them. These are symptoms of a loss of self-respect by people who cannot respect what they do not know." This is a book to call for the attention, the reading and the study of all persons who are perturbed by the rising tide of medical and other specialists who are less than literate except in their own specialties.

Clinical Studies in Psychiatry. By Harry Stack Sullivan, M.D. 386 pages including index. Cloth. Norton. New York. 1956. Price $5.50.

This reviewer found it a frustrating experience to read this book. Sullivan did not write with "the tongues of men and angels." Nevertheless this work contains many useful clinical pearls; and many more are probably hidden by its abstruseness. The section on therapy, especially the therapy of schizophrenics, is well worth reading for those interested in deep therapy.

Family: Socialization and Interaction Process. By TALCOTT PARSONS and ROBERT F. BALES. xi and 442 pages. Cloth. Free Press. Glencoe, Ill. 1955. Price $6.00.

With their collaborators, Parsons and Bales have produced a brilliant volume in *Family: Socialization and Interaction Process.* They intelligently challenge the widely-held belief that the American family is in a state of disorganization. Sociologically, the authors think there is strong argument that the American family has not lost its true function in our society, despite the high divorce rate, changes in sex morality, and even the decline in the birth rate.

Family: Socialization and Interaction Process is a collection of papers that are at times heterogeneous but, nevertheless, consistent in dealing with the central theme. This volume is a cross-cultural analysis in terms of psychological mechanisms, socialization process, and evaluation of role differentiations. There is so much vital information in it that it is unfortunate that the book too often involves academic considerations rather than less-involved facts, on the basis of which more people generally could benefit from the evaluations. However, it may well serve as a basic reference and is highly recommended for study by social and psychological workers, and teachers dealing with family units of all types.

The Lady and the Snake. By JOHN FARR. 149 pages. Paper. Ace. New York. 1957. Price 35 cents (in combination with *Nothing To Lose But My Life*).

Nothing to Lose But My Life. By LOUIS TRIMBLE. 169 pages. Paper. Ace. New York. 1957. Price 35 cents.

This paperback is another one of those things. Farr's story is compounded of sex and a book knowledge of abnormal psychology which is applied in more than doubtful fashion. The present wild-eyed tale concerns ophidiophilia which the author may or may not distinguish from ophidiophobia. The background is the snake house in the zoo; the zoology looks authentic to the outsider, and maybe it is. The book is better written than the average of such tales and the mystery fan may even enjoy it if he can forget his psychology.

It is bound with a novel by Louis Trimble, *Nothing to Lose But My Life,* which has fewer psychological pretensions.

Alcoholism. By F. B. REA. 140 pages. Cloth. Philosophical Library. New York. 1956. Price $3.50.

The author is antagonistic to psychiatric treatment of alcoholism, mustering confused arguments against psychiatry, and dwelling upon the marvels of Alcoholics Anonymous, without even attempting to explain the psychological mechanisms involved in A.A.

The Plague of Psychiatry. A Diagnosis, a Warning and a Call to Christian Action. By DORIS G. SIMPSON. 46 pages with bibliography. Cloth. Greenwich. New York. 1957. Price $2.00.

Besides being a pitiful document, *The Plague of Psychiatry* is an unusually lucid exposition of her reactions by a woman who has been hospitalized as a mental patient. Psychiatrists are "modern sorcerers" who, among other things, "attend lectures in China and elsewhere, for instruction in the collectivity of communism, including collectivity of orgasm." Of her own experience, she says, "I was working quietly in an office, as happy and healthy as any one, or more so, with no problems, when suddenly the devil struck. You become a target for invisible voices and sensations and manipulation of body organs! Then there is continued persecution and finally organized steps in an effort to railroad you to a mental institution . . ." She calls for a new campaign, based on religion, "to 'deliver the captives' of psychiatry from the tyranny of 'seizures,' 'examinations,' 'tests,' 'therapy.'"

This book is of professional interest for at least two reasons. Its contents may be worth knowing, as it is a tract calculated to attract the attention of, and to prejudice, persons in need of psychiatric help. Second, it is well enough written and well enough organized for teaching purposes —a use which would doubtless horrify the author.

Why I Am Not a Christian. By BERTRAND RUSSELL. 266 pages including index. Cloth. Simon and Schuster. New York. 1957. Price $3.50.

Why I Am Not A Christian is a collection of short essays and articles dealing with the general subject of religion and ethics, and written by Bertrand Russell over a period ranging from some 15 to 30 years ago. The title essay was originally published as a pamphlet, selling for a few cents, by that useful, freethinking citizen, E. Haldeman-Julius. The other essays appeared variously. Russell, in a modern preface, notes that he is now no less opposed to religious orthodoxy than he ever was: "I think all the great religions of the world—Buddhism, Hinduism, Christianity, Islam and Communism—both untrue and harmful." Much, if not most of his discussion, nevertheless, is in agreement with the tenets of some of the modern liberal churches.

This book discusses sex morality, religious orthodoxy and ethics in general and for this reason is important to psychologists and sociologists. An interesting appendix written by the editor, Professor Paul Edwards, covers the disgraceful incident in which Russell was prevented from teaching philosophy at the College of the City of New York. If only for this report on prejudice and irrationality, this book is recommended reading.

The Patient and the Mental Hospital. MILTON GREENBLATT, M.D., DANIEL J. LEVINSON, Ph.D., and RICHARD H. WILLIAMS, Ph.D., editors. 656 pages including index. Cloth. Free Press. Glencoe, Ill. 1957. Price $6.00.

This is a book that could be read with profit by all state hospital personnel. There is valuable information for directors, other administrators, ward physicians, nurses and aides.

Many of the problems facing mental hospitals are defined and discussed. Suggestions for change are outlined.

It would appear from many of the statements in this and other recent books that one of the biggest roadblocks to a therapeutic atmosphere in a mental hospital is the apathy of the staff. At the nurse and aide level, this is probably a reflection of the lack of leadership by the medical staff. It is emphasized time and again, by different contributors to this book, that it is unrealistic to expect the psychiatrist to be the only one to have a meaningful or therapeutic relationship with the patient. There are too many patients and too few psychiatrists. The psychiatrist, rather, must be the leader of the team, the director and adviser to the nurse, aide, occupational therapist and other team members who are encouraged to set the therapeutic milieu and establish meaningful relations with the patient.

There are many examples in this volume to show the good work that many state hospitals have been able to accomplish in spite of low budgets and inadequate staffing. The moral is, of course, to utilize existing staff and facilities effectively before griping for more.

Induced Delusions. The Psychopathy of Freudism. By COYNE H. CAMPBELL, M.D. 189 pages including index. Cloth. Regent House. Chicago. 1957. Price $4.00.

The author seems to have a large, dull axe to grind.

Many of the author's criticisms of Freud, his pupils, and present-day analysts are justified. Some analysts, including Freud, have voiced similar opinions. But the author has gone from specific criticisms to repudiation and condemnation of all Freudian discoveries and of all psychoanalytic theory. This, in itself, is enough to discredit the book in the eyes of most people.

An amazing contradiction anti-Freudians often make is the condemning of Freudian principles on the one hand and showing their validity on the other. On page 16 the author gives a very clear incident where his analyst made a slip of the tongue; and he uses this to demonstrate the analyst's real feelings toward him in a way that would have pleased Freud by demonstrating how a slip can reveal unconscious feelings.

Mental Robots. By LEWIS ALBERT ALESEN, M.D. 107 pages. Paper. Caxton. Caldwell, Idaho. 1957. Price $1.50.

The author of this book wants to abolish public mental institutions and let private hospitals care for the mentally ill, which he thinks can be done by increasing Blue Cross and Blue Shield contributions to include "a reasonable amount of psychiatric care." The subscribers would have the additional income to do this by abolition of the income tax which, it appears, is "not just a simple device for the purpose of raising money for the federal government to conduct its affairs." The income tax is in reality, the author says, "a well-laid plan appearing directly as the second proposal in the Communist Manifesto (1848) of Karl Marx and Friedrich Engels."

Psychoanalysis Today. By AGNOSTINO GEMELLI, O.F.M., M.D. 149 pages. Cloth. Kenedy. New York. 1955. Price $2.95.

The book-jacket states that this is a Catholic approach to psychoanalysis. The author, a priest and a physician, should be well qualified to express his opinion from an unusual viewpoint.

In the first section of the book, Dr. Gemelli reviews Freud's theories and notes the various parts of those theories which he cannot accept. The sexual-repression issue seems to be the chief point of criticism by the author, although he often mentions Freud's anti-religious opinions. "In conclusion I think I have pointed out what is alive and what is dead, completely dead, in the field of psychoanalysis. Its deficiencies point to the desirability of employing other means of psychotherapy. On the other hand, the explorations of the unconscious carried out by Freud reveal the necessity for completing psychotherapeutic action by reference to the priest and the employment of supernatural means in helping neurotics carry the load of their painful existence. With the help of the clergy it is possible to integrate and perfect the responsibility we have toward neurotic patients. In future the Christian doctor and the priest can give him back the possibility of accepting the sufferings of this life for the supreme purpose of human existence."

In section two the author takes apart the analytic psychology of Jung and attempts to show that Jung, like Freud, did not seriously consider religion in his theories but persuaded certain Christian, especially Catholic, theologians to accept his ideas. "In fact, if the patient whom the doctor is treating is a believer, or at least a person who was born a Catholic and who, because of the conditions of his life has abandoned religious practice temporarily, a therapy that is kept on a purely psychological and psychiatric plane will not be effective. . . . Naturally, a physician must not be asked to substitute for a priest, just as it would be a grievous mistake for a priest to practice psychotherapy."

Section three contains the author's comments on the views of His Holiness Pius XII, given at the Fifth International Congress of Psychotherapy and Clinical Psychology on April 13, 1953.

The reviewer could leave this review as it is; but after reading several books of this type, he might feel like suggesting that if a person is dissatisfied with the theories already proposed, he might stop criticizing and develop one which is satisfying, is original and is possible for that person to promulgate.

Ancient Voyagers in the Pacific. By ANDREW SHARP. 240 pages including index. Paper. Penguin. Baltimore. 1957. Price 85 cents.

This is a well-done, well-documented and probably important book on the subject of the early voyaging which led to the dispersal of the Polynesians over the islands of the Pacific. Sharp believes, on the authority of Cook and other early explorers, that accidental voyaging has always been prevalent in the Pacific, that long deliberate voyaging never has been, and that the Polynesians were dispersed from three great centers, the west, the central islands and the east, chiefly by vessels accidentally blown off course to new islands. This is in contravention of the conventional belief that the islands were settled by deliberate exploration from the west. It is in equal contravention, of course, of Thor Heyerdahl's belief that the islands were settled largely by a mass emigration from South America—a theory more impressive to laymen that attractive to the professionals.

Mr. Sharp's book is very well done and is very impressive. It would be considerably more impressive if he had not gone dashing madly off into what used to be called the "fallacy of the consequent." (If a man is a drunk, he becomes destitute; therefore, if a man is destitute, he is a drunk.) A completely imaginative voyage, Sharp holds, contains supernatural incidents. Therefore, all voyages in which supernatural incidents are prominent are completely imaginary. He includes Leif Eries' son, for this reason, in his list of imaginary voyagers. He should have included Columbus as well. And, considering his main thesis of accidental exploration in the Pacific, he should have explained, in reference to Leif, how Norse voyagers, sailing regularly between Iceland and the settlements of accidentally-discovered Greenland, could possibly have avoided accidental discovery of North America.

This reviewer has seen reasoning (Lord Raglan's *The Hero*) by which the fallacy of the consequent could be used to prove that Sargon of Accad, never lived.

This kind of illogic casts suspicion on the rest of a work which appears otherwise to be important to students of man and his society.

Hypnography. By AINSLIE MEARES. 271 pages including index. Cloth. Thomas. Springfield, Ill. 1957. Price $7.75.

Hypnography is a sub-technique of hypnoanalysis, developed by the Australian psychiatrist, Ainslie Meares. In the process of hypnography, the patient is first hypnotized, then instructed to paint something that interests him. Not unexpectedly, the paintings have turned out to be of great dynamic, specifically psychosexual, significance. Dr. Meares' book is a description of the method, its rationale, the means of obtaining associations by it, its psychodynamics, its symbolism and excerpts from case histories. He sums up with a discussion of general considerations concerning the method and with an evaluation. It is to be noted that the author finds the procedure not without dangers, and that the dangers are those that are common to all hypnotic methods.

The volume is illustrated with more than 200 figures, in black and white, of the patients' productions. There are excerpts from five case histories, giving associations to the paintings. It is of interest to note that although hypnography is not a method of treatment in itself but "merely an aid to hypno-analysis, which is itself an aid to psychotherapy," Meares can report improvement in three of the five cases treated by it. In one case this was limited to symptomatic improvement during treatment; in a second, there appeared to be symptomatic recovery and in a third the author merely reports that the patient has been less tense and that his impulsive violence has ceased. Meares does not note results in Cases 4 and 5.

The present book concerns work with chronic psychoneurotics of poor prognoses. The book is primarily descriptive. Meares points out that the technique is still experimental and that the publication is done "in the hope that the technique will be tested in the hands of other workers." It appears to the reviewer that this book will be of great interest and probable value to all clinicians who make use of hypnosis.

Academic Freedom. By RUSSELL KIRK. 210 pages with index and bibliography. Cloth. Regnery. Chicago. 1955. Price $3.75.

This is a smoothly written, persuasive volume by the author of *The Conservative Mind* and *A Program for Conservatives*. The author's treatment is broad and his analysis clever; he thinks some of the strongest defenders of academic freedom to be themselves offenders against it. He believes, however, that the higher learning should be dedicated among other things: "To the proposition that the higher imagination is better than the sensate triumph. To the proposition that the fear of God, and not the mastery over man and nature, is the object of learning. . . ." He speaks scornfully of Hutchins' definition of the American faith as including "reliance on reason to advance society." His viewpoint is not one to commend itself to scientists.

Mother and Child. A Primer of First Relationships. By D. W. Winnicott, M.D. 210 pages including index. Cloth. Basic Books. New York. 1957. Price $3.50.

It is not often in fiction that an author is able to convey to the reader a feeling or identification for the subject he is discussing, whether it is a character in the book or a description of a situation or scene. In nonfiction, this accomplishment is even rarer. But when it is done, the book becomes a classic or at least very meaningful and valuable. It is often incorporated by the reader as though he had in real life experienced the same thing. This is such a book.

So many books have been written telling mother what to do about every conceivable situation that may come up with her baby. So many child psychiatrists have laid the "blame" at mother's feet whenever something has gone wrong with the child. There has been so much stress on symptoms such as enuresis, thumb-sucking, and food idiosyncracies as being indicative of mental illness that many mothers have become anxious and depreciative of their capacity to be mothers.

It is refreshing to read a book by a child psychiatrist who restores some dignity and understanding to the role of the mother. The book's aim is "to do what is so much needed at the present time—to give moral support to the ordinary, good mother—and to protect her from everyone and everything that gets between her baby and herself." This moral support is not given through transparent platitudes, with the idea that if mother is told she is a good mother, it will bolster her ego and enable her to do a good job. Rather, the author supports the good mother by conveying to her that she and her baby are the best judges and critics of their relationship. This helps her to stand up against the well-meaning advice of Granny and the other experts, those self-appointed, and those with degrees and diplomas.

The reviewer thinks that mother will be helped more if psychiatrists, pediatricians and nurses read this book than she will be if she reads it herself. Perhaps this book will encourage some professional people to inspect their own attitudes which, in themselves, with the effect on the mother, may interfere with the mother-baby relationship.

Wish I Might. By Isabel Smith. 234 pages. Cloth. Harper. New York. 1955. Price $3.00.

This is the autobiography of a tubercular patient, suffering for 21 years and finally helped. Her wish to live is remarkable, and the description excellent. Her "fierce thirst for life," unfortunately, was not combined with psychological curiosity. But as a monument of courage and endurance, this book is valuable.

Directory of American Psychological Services. 1957. American Board for Psychological Services, Inc. 156 pages and index. Paper. Distributed by American Board for Psychological Services, 9827 Clayton Road, St. Louis, Mo. Price $1.00.

This is a useful directory for any institution or individual having occasion to refer anybody for any sort of psychological service. It lists institutions ranging from universities to public schools and other public agencies, and covers private consulting groups and individuals. It does not comprehend all the qualified psychologists or services in the United States but does offer a reasonable selection for the use of persons who may need to make referrals.

English Eccentrics. By DAME EDITH SITWELL. 376 pages including index. Cloth. Vanguard. New York. 1957. Price $5.00.

Dame Edith Sitwell stirs up a magnificent kettle of fish stories. Unlike the typical fish story, her tales, however, are either true beyond suspicion or well documented. She visits the Carlyles and that extraordinary man, Charles Waterton, who explored South America in his youth, was faithful all his life to the memory of his dead child-wife, and at the age of 77 scratched the back of his head with his right big toe. Waterton was a genuine and an extraordinary person. The author pays attention as well to Herbert Spencer, Edward Montague and the prodigious old man, Parr, who died at the supposed age of 152 after a far-from-sedate career as a senior citizen. She writes of such notables as Squire Mytton, a dashing and somewhat pitiful fellow who, among other exploits, once set his nightshirt afire to cure the hiccoughs. There is also a sketch of Capt. Thicknesse whose will directed that his right hand be cut off and sent to his undutiful son. There are notes of a number of rascals, including the ghoulish crew who may or may not have desecrated the grave of Milton.

This is an exceedingly entertaining book and should be enjoyed in particular by persons whose professional contacts with psychopathology are seldom as amusing.

The Education of Young Children. By D. E. M. GARDNER, M.A. 118 pages. Cloth. Philosophical Library. New York. 1957. Price $2.75.

This is a warm, intimate book written by the head of the department of child development at the University of London Institute of Education.

The subject is the nursery school child—who is not something to be manipulated like a piece in chess. He is recognized as an individual for whom norms cannot only not be established but for whom they would be misleading. This book will make valuable reading for the parent, teacher and social worker.

Materials Toward A History of Witchcraft. HENRY CHARLES LEA, collector. 1,548 pages, boxed, in three volumes. Cloth. Yoseloff. New York. 1957. Price $20.00 per set.

Lea's work is not a history of witchcraft but exactly what the title states—materials for the writing of one, which he probably would have undertaken if he had not died at 84 before his collection was completed. The three volumes are, then, a series of citations from an enormous variety of sources, with Lea's scholarly comments on them. They have been carefully edited and arranged by Professor Arthur C. Howland who occupies the chair of European History named for Dr. Lea at the University of Pennsylvania.

Witchcraft is usually discussed by psychiatrists in the light of mental disorder. It was, many feel, a persecution of harmless but annoying neurotics and ambulatory psychotics. The authorities and the church, in this view, harried, tortured and murdered innocent sick people.

Another view is that witchcraft represents the survival of paganism. Those who accept this explanation see it as a more or less well-organized minority religion, suppressed with great cruelty by established Christianity.

Lea's point of view appears primarily neither of these. It does not necessarily follow that he would deny the survival of all vestiges of paganism or that he would be blind to the mental disorders of those who were held to be wizards and witches. He did, however, apparently consider these matters not fundamental. Lea's theory of witchcraft emerges plainly from his notes. Witchcraft in his view seems to have been the creation of the religious authorities, who developed a theory of devil worship possibly without realizing their role as creators and attached it to the primitive sorcery of the early middle ages—as a weapon to combat heresy. Whereupon, the monster they created got away from them.

Whatever witchcraft was or is, there are still traces of it in remote rural sections of both Europe and America. Mental patients frequently bring witchcraft into their delusions. The whole creation is at the foundation of modern superstitions of all varieties. *Materials Toward A History of Witchcraft* forms an invaluable source for all students of this sort of aberration, social or personal.

Psychology in Teaching. By HENRY P. SMITH. 466 pages. Cloth. Prentice-Hall. New York. 1954. Price $4.95.

"The purpose of this book is to give the prospective teacher a chance to acquire training in educational psychology." Intended as a text in educational psychology, it might serve as a short survey of the entire psychological field, its coverage is so complete. The weightier problems are treated superficially, but the book is intended for the student teacher who may be without past psychological training.

Recovery from Schizophrenia. The Roland Method. By JOHN EISELE DAVIS, D. Sci. 162 pages. Thomas. Springfield, Ill. 1957. Price $4.75. 1957. Price $4.75.

This book is a description, analysis and evaluation of the Roland Method of the treatment of the regressed, chronic patient with catatonic schizophrenia.

The title of the book is somewhat misleading as Mr. Roland is not so presumptuous as to claim recovery. "I don't want you to think that we believe that we have any miracle cure. The main thing we are trying to do is make the patient accessible to a higher form of therapy."

The reports from the hospitals, where Mr. Roland worked, indicate he was able to achieve his aims with patients who had been tried on electric shock treatment, insulin shock and psychotherapy and were so-called treatment failures.

As the author points out, the Roland method may not result in the patient leaving the hospital; but, even if the patient makes a better adjustment in the hospital, this is a satisfactory accomplishment.

New Directions in Psychoanalysis. MELANIE KLEIN, PAULA HEIMANN and R. E. MONEY-KYRLE, editors. 534 pages including index. Cloth. Basic Books. New York. 1956. Price $7.50.

This book is a reproduction of 21 essays, 11 of which appeared in the *International Journal of Psychoanalysis* in March 1952 in dedication to Melanie Klein on her seventieth birthday.

Most of the essays will be of interest to a small group because of the broad knowledge of psychoanalysis that is needed to read them intelligently.

Furthermore, many of the ideas expressed are hypothetical and controversial and have little application for the clinical psychiatrist apart from such psychoanalysts as are well informed on Melanie Klein's own special principles.

The Sexual Offender and His Offenses. By BENJAMIN KARPMAN, M.D. 744 pages including index. Cloth. Julian Press. New York. 1954. Price $10.00.

This is an invaluable reference book for the clinical psychiatrist. It is divided into two sections: one, a review of the literature from 1912 to 1951; and two, a discussion of the psychodynamics of sexual offenses and a formulation of the problem they create. In addition, there is an extensive bibliography and a chapter on suggested questions for a psychogenic inventory.

Copernicus. By Angus Armitage. 236 pages including index. Cloth. Yoseloff. New York. 1957. Price $5.00.

This discussion of Copernicus' life and works and their results reports material covering several centuries of development which ought to be familiar to all scientists. The slow progress in the history of astronomy has been paralleled in the history of medicine and in particular in the history of medical psychology. What Copernicus did was the beginning of centuries of slow and painful development. Copernicus threw off some of the ill-founded beliefs of his day but he did not, as the general reader commonly supposes, develop today's theory of the solar system. Copernicus made a beginning toward ridding the world of the Ptolemaic theory that the earth was the center of the universe, but his heliocentric theory retained Ptolemy's perfect circles as paths of the heavenly bodies and he retained and modified Ptolemy's epicycles to explain apparent aberrations. It was not until a century later that Kepler broke with these superstitious beliefs to demonstrate that the orbits of the planets were not epicycles (of perfect circles) on perfect circles but were ellipses.

Armitage covers this record of painful progress in a surprisingly compact book and in language which the student of other sciences than astronomy should be able to understand. It is an excellent work to exemplify the general problem of scientific development, as well as the social and psychological forces which have hampered all scientific progress since prehistoric times.

Digging Up Jericho. By Kathleen Kenyon. 272 pages including index. Cloth. Praeger. New York. 1957. Price $5.50.

The expedition headed by Kathleen Kenyon made the startling discovery that the city of Jericho was, by thousands of years, the oldest town in the world. Commonly, Mesopotamia and Egypt have been considered man's earliest civilizations, with recently-excavated Jarmo in Iraq marking the first, and still much earlier, stage of settlement which represents the transition of man from foodgathering to agriculture. But Jarmo dates to less than 5,000 B.C. Both Mesopotamia and Egypt are much later. And by 5,000 B.C. Jericho was already very old—perhaps several thousand years old. The Jericho discoveries are revolutionary for the history of human technology and are of equal interest for the unexpected light they cast on early man's feelings and ideas. It has long been supposed that man made pottery before he founded cities. But civilized men lived in the city of Jericho for many centuries before they made pottery. They had "all the attributes of civilization, except that of a written language." They used stone bowls, stone tools and doubtless implements of wood and bone—in 7,000 or 8,000 B.C.

In this almost unthinkably early city there are unmistakable evidences of religious belief. There are figurines of what appears to be the Great Mother Goddess; and the Jericho people preserved the skulls of their dead and covered them with plaster features in what looks like portrait statuary, apparently another evidence of very ancient religion, homage to the dead ancestor. Early Jericho may be as important in tracing the history of human thought as in tracing the history of the arts and crafts of our earliest urban civilization to beginnings of hitherto unsuspected antiquity.

The remains of Jericho are, in fact, so very old that Joshua's conquest in Biblical days was too recent to have left certainly-identifiable traces; thousands of years of wind and rain have swept the relics of Joshua's ancient day from the face of the still far more ancient ruins.

Nightcrawlers. By CHAS. ADDAMS. 96 pages. Cloth. Simon and Schuster. New York. 1957. Price $3.95.

Addams' latest is some 90 pages of witchcraft, sadism and pure schizophrenia. As a bedtime book, it should give nightmares to the most tough-minded. Beastliness reflects from the barber's mirror, and shows in a "moonlight" visit to the planetarium. Specimens of prehistoric, medieval and modern eeriness are all mixed up. Addams' zombi family haunts the pages with torture and grisly fantasy. Gargoyles come to life. A student concludes a modern compact with the devil and is about to graduate magna cum laude and make a start in the business world as copy chief "at B.B.-D.&O.," which the initiated will recognize as one of the foremost advertising agencies in America.

These cartoons are a fine way to sublimate a little sadism harmlessly, or maybe a little masochism. They are not recommended as entertainment for the depressive or the markedly schizoid.

The Scythians. By TAMARA TALBOT RICE. 255 pages including index. Cloth. Praeger. New York. 1957. Price $5.00.

Somewhere in the direct ancestry of the western world there was a nomadic, artistic illiterate people who swept over the lands of the south, and by amalgamation created the civilization from which ours has arisen. The Scythians were not those folk. They came too late in prehistory or history, but they must have been much like them. It may surprise some students to realize the high order of Scythian civilization and the very fine art that the Scythians created. They also achieved an oddity in the way of social organization, an apparent combination of cities with an agricultural fringe and a great pastoral nomadic hinterland. There are few clear and comprehensive accounts of these people available anywhere and the present volume is probably the best yet presented in English. It should be of interest to any student of civilized man's origins.

Drugs and the Mind. By Robert S. de Ropp, Ph.D. 310 pages including index. Cloth. St. Martin's Press. New York. 1957. Price $4.50.

This book comes at a very appropriate time, when the psychiatric world is absorbed by the treatment of mental illnesses with drugs. The author presents an interesting history of drugs that are used to alter mental processes and mental states. He also describes the reaction of the mind to these drugs by quoting from the experiences of those who have used them.

Many opinions are expressed that have aroused controversy: i.e., opium and morphine addicts should be treated as sick people; the use of marihuana, per se, does not lead to crime; and others.

The poorest chapter in the book, by far, is the one describing the "tranquilizing" drugs. They receive high praise for their efficacy in the treatment of mental illness. The book does not mention that many psychiatrists dispute this—and thus gives an incomplete picture.

The last chapter discusses the future possibilities of drugs for the mind. The author is undecided as to their ultimate value. But he leaves no doubt that their force will be felt, whether to push man higher up the ladder or further down.

Tales of a Teacher. By Beatrice Stephens Nathan. 302 pages. Cloth. Regnery. Chicago. 1956. Price $4.00.

Beatrice Stephens Nathan has written one of the most enjoyable stories of a teaching career which this reviewer has encountered. There are details of the country school of 50 years ago, of the high school of a generation past and of the modern school. Anybody concerned with the education of our youth should be interested in this book and find it enjoyable, but there is more than that.

The author winds up with some brief, well chosen and biting observations as to the current state of education. She lays the blame at the door of the educationist and progressive education fads. She feels that the teachers themselves, who may have suffered the most from the modern state of affairs, are the people who ought to be asked or coerced into doing something about it. Teachers belong on boards of education, she thinks.

She would let the administrators administer; but "let the responsibility for the curriculum and the methods of instruction be placed where it belongs: in the hands of the teachers." The teachers themselves, the author feels, have little sympathy with the anti-intellectualism, the fads, the failures and the superficialities of modern teaching and for the excuses rationalizing them. Her book, on this score alone, calls for the serious attention of people who are convinced there is much wrong with our schools and that something should be and could be done about it.

Lives in Science. Scientific American. 274 pages. Paper. Simon and Schuster. New York. 1957. Price $1.45.

New Chemistry. Scientific American. 206 pages. Paper. Simon and Schuster. New York. 1957. Price $1.45.

The Planet Earth. Scientific American. 168 pages. Paper. Simon and Schuster. New York. 1957. Price $1.45.

Plant Life. Scientific American. 237 pages. Paper. Simon and Schuster. New York. 1957. Price $1.45.

The Universe. Scientific American. 142 pages. Paper. Simon and Schuster. New York. 1957. Price $1.45.

This is the second annual set of basic scientific works made up of articles originally presented in the *Scientific American*, and ranging in the present case from cosmology to the newest developments in chemistry. They are all informative. They all would find a place in any general scientific library, and most of them would make excellent supplemental reading in science courses.

Of principal interest to psychologists and psychiatrists is the volume, *Lives in Science*, which covers notables from Galileo to Srinivasa Ramanujan, the mathematical prodigy.

This volume is a collection of excellent sketches of, or essays on, the men who have made the modern scientific world. The psychiatrist will be particularly interested in the sketch of Isaac Newton, with his baffling personality characteristics; that of Benjamin Franklin and those of William Harvey, Charles Darwin and Pavlov. This book in particular belongs in any library used by students of the social and psychological sciences, and the others would be far from out of place there.

Does Man Survive Death? Eileen J. Garrett, editor. 204 pages. Cloth. Helix Press. New York. 1957. Price $3.75.

Eileen Garrett is widely known as a "sensitive," a woman of wide personal experience with various ESP phenomena. She is also known as a competent editor and a person who can express her convictions without fanaticism.

The present book is her selection of pertinent material on the question of survival after death, from the standpoints of philosophy, parapsychology, science, religion and psychical research. The religious material covers orthodox interpretations as well as spiritualism.

For the psychotherapist, there are at least two good reasons for interest in this volume. It gives at least sketchy views of the backgrounds which he may encounter in the beliefs of his patients. It provides some of the answers to the question, "Is this personal delusion or recognized religious belief?" The second reason is that there is some sober examina-

tion of the question by recognized scientific workers. Emanuel K. Schwartz contributes, as a psychoanalyst, a short and stimulating paper on the "psychodynamics of 'immortality' study." R. A. McConnell writes as a physicist on the changes in basic theory brought about by Heisenberg's uncertainty principle. J. B. Rhine discusses laboratory problems. He holds that we have established "that there is in personality something more than its physical substrate," and that the task of the research worker is to go on from there. Mrs. Garrett contributes a brief introduction in which she states that she does not know the answers. That seems to be a fair measure of the objectivity with which this material was selected and is now presented here.

Music in Your Life. By DELOS SMITH. 272 pages. Cloth. Harper. New York. 1957. Price $3.95.

This book is made up of brief sketches of 46 composers beginning with Palestrina and Monteverdi and including all the great composers, past and present.

In spite of the brevity of each biography, the author has presented a reasonably complete and interesting picture of each one. This book should be of interest to the music lover who is desirous of knowing something of the composers' private lives apart from their music. It may be disillusioning to some to see how poorly most of the geniuses regulated their lives. Many of them were unhappy and maladjusted, but we can be thankful for their creativeness.

Peru. By G. H. S. BUSHNELL. 207 pages including index. Cloth. Praeger. New York. 1957. Price $5.00.

There has been much plodding work and a good deal of consequent progress in the archeology of Peru in the last 30 years. The civilization of the ancient Peruvians has always been fascinating because it was virtually wiped from the earth and has had to be reconstructed, and because it included a number of features uncommon to antiquity elsewhere. The Inca, as is well known, had achieved something of a "socialist" totalitarian society. They had also made progress in some of the modern arts and sciences which was unparalleled in the ancestry of our own civilizations. Dr. Bushnell has written a comprehensive and most readable account of ancient Peru in the light of modern discovery. He has concentrated on pre-Incaic rather than Inca times. In disagreement with some other modern students, he thinks the Tiahuanaco culture must have been spread at least in part by military force. Of interest to medical people is his belief that trepanation probably had a religious explanation. He says: "Whatever the reason, the victims survived the operation, and not once only."

Psychological Disorder in Crime. By W. Lindesay Neustatter, M.D. 248 pages including index. Cloth. Philosophical Library. New York. 1957. Price $6.00.

This is a psychiatric book intended for the legal profession and laymen. It describes the various character disorders, neuroses and psychoses.

The last chapter discusses whether the criminal offender should be punished or treated.

This reviewer does not think this book will be too helpful to the legal profession. Lawyers and judges do not want classifications and descriptions of mental diseases. They might like to know why some psychiatrists feel a person is mentally ill and not responsible for an act, even though he knows the nature of his act and that the act is wrong in the eyes of society—or why some psychiatrists feel that sexual perversion is an illness of the mind—or why some psychiatrists feel that the unconscious mind can control conscious behavior. It seems to this reviewer that these are some of the questions that cause animosity between the medical and legal professions largely because the judge and lawyer do not understand why the psychiatrist thinks the way he does. Unfortunately, none of these questions are covered in this book.

A Measure of Love. By Iris Origo. 247 pages. Cloth. Pantheon. New York. 1957. Price $4.50.

The author gives us in this volume biographical studies of five people of the nineteenth century. Some of the figures are well known—Byron, Carlyle, Mazzini—others less so, but all are emotionally immature and highly unpleasant characters.

The book should be of interest, both to psychologists and to students of English literature.

Some Slips Don't Show. By A. A. Fair (Erle Stanley Gardner). 187 pages. Cloth. Morrow. New York. 1957. Price $2.95.

Unfortunately, in this one, the author's slips do show. Both plot and humor are inferior to the previous amusing Bertha Cool-Donald Lam stories. Psychologically, Fair, alias Gardner, can be relied upon to be accurate; though insight is not always guaranteed, but interest in this story lags, and the impression is of a tale hurriedly put together.

The Amazing Crime and Trial of Leopold and Loeb. By Maureen McKernan. 299 pages. Paper. Signet Book-New American Library. New York. 1957. Price 50 cents.

A recapitulation of the notorious Leopold and Loeb case, this book contains the joint medical report of Drs. White, Healy, Glueck and Hamill; it also includes Clarence Darrow's summation.

The Loyal and the Disloyal. By MORTON GRODZINS. 264 pages. Cloth. University of Chicago Press. 1956. Price $4.00.

A confused and confusing book is written by the chairman of the department of political science, University of Chicago, author of *Americans Betrayed*, dealing with the relocation of Japanese-Americans on the West Coast during World War II. This time, the conclusion reads, "No man is wholly patriot or wholly traitor, but every man is a little of each." The whole book seems some kind of protest against the loyalty program, using ambiguous and sometimes psychologically unsophisticated arguments. It is a rather regrettable performance, open to misunderstandings.

American Literature and the Dream. By F. I. CARPENTER. 207 pages. Cloth. Philosophical Library. New York. 1955. Price $4.75.

The author investigates the relations of important writers to the American dream of realizing a more perfect liberty and democracy in the new world. He arrives, for example, at these conclusions: "And throughout his life Melville denied the real possibility of the democratic dream, even while reaffirming its desirability. By contrast, Emerson and Whitman affirmed both its possibility and its value, while Hawthorne remained doubtful whether individual freedom was truly desirable in this sinful world." The American dream is certainly a wonderful and desirable precept; so far, the reviewer agrees with the author. But the author completely ignores, or disregards, unconscious motivations; he takes surface manifestations at face value. The book is a psychological anachronism.

This is Goggle. By BENTZ PLAGEMANN. 243 pages. Cloth. McGraw-Hill. New York. 1955. Price $3.50.

A mildly humorous novel deals with the education of a father, confronted by the troubles created by his son from the ages of 10 to 18. The father is mostly perplexed, the son mostly unaffected. A happy ending seems to prove that the decision over the child's future depends on inner factors. The humor is thin, though benevolent.

Psychopathic Personalities. By HAROLD PALMER, M.D. 179 pages including index. Cloth. Philosophical Library. New York. 1957. Price $4.75.

This is a well-written basic book which contains, in addition to a description of all the functional illnesses, a very concise chapter on the epilepsies. This book is an excellent introduction to psychiatry, for residents, for psychiatric social workers and others who need some background of clinical psychiatry.

Energy and Structure in Psychoanalysis. By KENNETH MARK COLBY. 146 pages. Cloth. Ronald Press. New York. 1955. Price $4.50.

Every young student of analysis goes through a period of demoting the already known, and attempting to prove that everything must be revamped. This can be done with more or less taste, with more or less sound arguments.

In the case under scrutiny (the membership roster of the American Psychoanalytic Association lists the San Francisco author as a member since 1954), the pretensions are great, the language conceited: "Today we need not denounce our psychoanalytic predecessors as much as pleasantly bid them good-bye and thanks." The author objects to Freud's analogies in trying to explain the psychic apparatus. Freud's constructs are "modernized," mostly by using incomprehensible terms. In this reviewer's opinion, the book can be written off as the product of a very young analyst who has a lot to learn before teaching others.

The Psychiatrist and the Dying Patient. By K. R. EISSLER. 317 pages. Cloth. International Universities Press. New York. 1955. Price $5.00.

After plunging through this book, purporting to be a forerunner of the science of "orthothanasia" (defined by the author as "a right, true, or proper manner of dying"), this reviewer regretfully concludes that the author has produced an utterly confused work. The main thesis is that "the psychiatrist has his rightful place at the side of the deathbed" and has something important to contribute to the "proper" manner of dying. This main thesis, the reviewer thinks, is fallacious. The author underestimates the number of people for whom religious beliefs solve the problem —he talks of this majority as if it were an infinitesimal minority. Nonbelievers die either with illusions (if permitted) concerning the gravity of their illnesses, or, if informed of the approaching end, with unmitigated masochistic suffering, slightly diminished by drugs. Psychiatry in the reviewer's opinion has nothing to contribute to the process, since psychiatry works in neurosis on the basis of an unwritten promissory note, "Give up some of the infantile defenses; and your life will be less conflictuous in reality, and pleasures inaccessible to you in neurosis, will be within your reach." With a dying person, this premium is non-existent, hence psychiatry is out of place.

To reach higher levels of confusion, the author holds that the psychiatrist treating psychotherapeutically a sick person in terminal phases, must conform to three requirements: pity, sorrow, and—magic partial belief that "the patient is ultimately immortal." This has nothing to do with religious beliefs, emphasizes the author, but with animistic convictions. On the basis of this triad, the psychiatrist has to give the patient a "gift,"

consisting of affection. In short, transference phenomena are used as a crutch, although this does not explain why any person with tact and commiseration could not perform a similar task.

The reviewer cannot see the slightest reason for the author's assumption that "the psychiatrist would take over directly the function of the priest, or the minister and simultaneously prove the superiority over the religious approach which comes to a quick end when man has lost his faith in God." Though Eissler acknowledges that the psychiatrist should not touch religious beliefs in moribund people, and is even glad to find sincere religious feelings in the patient, his view of the future is in contrast with present-day opinions of the majority of psychiatrists who see neither a contradiction between religion and psychiatry, nor the practical extinction of religious feelings in many patients.

Le Delirium Tremens. By R. Coirault, M.D., and H. Laborit, M.D. 140 pages with tables and bibliography. Paper. Masson et Cie. Paris. 1956. Price 1,200 fr.

Alcoholism has shown a steady rise in France with a concomitant increase in delirium tremens. The symptoms and differential diagnosis of the latter illness are briefly reviewed in this French work. Particular attention is given to potassium body content, with reduced elimination of potassium in the urine found fairly constantly—pointing to an overloading of the cells with potassium. The changes in nerve-muscle excitability, their prognostic significance, and reversal to normal after treatment are described. The psychological background of patients with delirium tremens receives some attention. Delirium tremens is considered a diencephalic disorder, although the evidence offered is somewhat meager.

The therapy of delirium tremens (vitamins, infusions, sedation, chlorpromazine, hibernation) is enlarged by the use of a new steroid, the sodium succinate salt of 21 hydroxy-pregnandione. This agent is described in detail, with case reports illustrating its dramatic effects.

The book could have benefited by a greater elaboration of the data underlying some of the hypotheses. The case histories and therapeutic outlines are well written, and in general this is another example of the excellent clinical work being done today in France.

What I Have Learned By Living. By Henry J. Burt. 147 pages. Cloth. Humphries. Boston. 1955. Price $3.00.

A religious treatise is written by a sociologist, who arrives at optimistic conclusions: "Through the development of these resources, it is possible as never before in the world's history, to spin the threads of Truth and Beauty and to weave them into the fabric of the Good Life."

CONTRIBUTORS TO THIS ISSUE

ERIC BERNE, M.D. Eric Berne is a psychiatrist in private practice in Carmel, California. His paper in this issue of THE PSYCHIATRIC QUARTERLY is the fifth in a series of articles on the general subject of intuition. Three of the previous four also appeared in this journal. Dr. Berne studied at McGill, where he received his medical degree in 1935; at the Yale Institute of Human Relations; and at the New York and San Francisco psychoanalytic institutes.

Dr. Berne is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and is a fellow of the American Psychiatric Association. He was formerly a consultant for the United States Army, an attending psychiatrist for the Veterans Administration, and a member of the outpatient staff at Mount Sinai Hospital, New York City. He has special interests in group therapy and in psychotherapy in general. He is the author of numerous scientific articles and of a popular book on psychiatry, *The Mind in Action*.

MAURICE R. GREEN, M.D. Dr. Green was born in Chicago. He attended college and medical school at Northwestern University, obtaining his medical degree in 1946. He served a rotating internship at Passevant Memorial Hospital in Chicago, then served in the army as a neuropsychiatrist from 1946 to 1948. He later completed his residency in psychiatry at the Veterans Administration Hospital in the Bronx, New York. He received his certificate in psychoanalysis from the William A. White Institute of Psychiatry in 1954.

Dr. Green is an associate attending psychiatrist at Roosevelt Hospital, New York City, where he began attending at the child psychiatry clinic in 1950. He is consultant for the Bleuler Psychotherapy Group and for Brookwood Hall. Among his other interests, he is a member of the Board of Advisors of the Institute of Jazz Studies, Inc., New York City, and a member of the Board of Advisors of Spring Lake Ranch, Cuttingsville, Vt. He is certified in psychiatry by the American Board of Psychiatry and Neurology.

DAVID SCHECTER, M.D. Dr. Schecter received his medical degree from McGill University in 1950. He served at Bellevue Psychiatric Hospital, New York City, 1951-53, and then at University Hospital Psychiatric Clinics, New York City, 1953-54. He is a candidate for the certificate in psychoanalysis at the William A. White Institute of Psychiatry, and an assistant attending psychiatrist at Roosevelt Hospital.

JAMES E. RAPPA, M.D. Dr. Rappa is a graduate of the Long Island College of Medicine, 1933. He interned at Nassau Hospital, Mineola, and joined the staff of Brooklyn (N.Y.) State Hospital in 1935. He served in the armed forces from 1941 to 1946, and, at the time of his discharge, was a lieutenant colonel and chief of the neuropsychiatric section of an overseas general hospital.

Dr. Rappa is now assistant director of Brooklyn State Hospital and clinical associate professor of the State University Medical School in New York City. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. He is a fellow of the American Psychiatric Association, a member of the American Group Psychotherapy Association, and the Eastern Psychiatric Research Association.

HERMAN TANOWITZ, M.D. Dr. Tanowitz received his medical degree from Zurich University, Switzerland, and subsequently interned at Beth El Hospital, Brooklyn. His initial training in psychiatry was obtained at Manhattan (N.Y.) State Hospital, and he is now a senior psychiatrist at Brooklyn State Hospital.

LUDWIG EIDELBERG, M.D. Dr. Eidelberg is in psychoanalytic practice in New York City. Born in 1898, he was graduated in medicine from the University of Vienna in 1925. He is clinical associate professor of psychiatry at the State University Medical Center, is vice president of the New York Psychoanalytic Society and a faculty member of the New York Psychoanalytic Institute.

MAURICE KLOTZ, M.D. Dr. Klotz, born in Belfast, Ireland, in 1906, became an American citizen in 1928. He is married, has three children, and lives in Highland Park, Ill.

Dr. Klotz received his M.D. from the University of Illinois College of Medicine in 1934. His general rotating internship was at the University of Illinois Research and Educational Hospital from 1933 to 1934. He had a residency in internal medicine at Chicago State Hospital from 1934 to 1945 and was on active army duty as a medical officer, Sixth Corps Area, from 1935 to 1937. He has been on Veterans Administration hospital staffs since 1937 with the exception of active duty in World War II from 1942 to 1945.

Since 1945, he has served as chief of acute intensive treatment services and other psychiatric services. He is author or co-author of various scientific articles. He has been at the Veterans Administration Hospital, Downey, Ill., since 1955, and is chief of the acute intensive treatment service there. He is a colonel in the medical corps, active army reserve;

is a fellow of the American Psychiatric Association and American College of Physicians; and is a member of other professional organizations.

He is the author of a number of scientific papers, including a previous contribution to this QUARTERLY.

PAUL FEDERN, M.D. The late Paul Federn was one of the pioneers of psychoanalysis. Born in 1871, he received his medical degree from the University of Vienna in 1895 and was a practising internist when he first turned his attention to psychoanalysis. He was one of the early pupils of Freud, was a pioneer member and acting chairman of the Psychoanalytic Society of Vienna, and was co-founder and co-editor of the German publication, the *Journal of Psychoanalytic Pedagogy*. He was intimately associated with Freud as co-editor of the *International Journal of Psycho-Analysis*.

His reputation was international when he came to this country after Hitler took over Austria. THE PSYCHIATRIC QUARTERLY published the first important contribution he made to the psychoanalytic literature after his arrival in this country, "Psychoanalysis of Psychoses," a paper which has become a classic on the subject and was re-published as part of his posthumously-printed book *Ego Psychology and the Psychoses* in 1953. Dr. Federn died in 1950 after several years of illness.

The paper published in this issue of THE PSYCHIATRIC QUARTERLY first appeared some years ago in German. Besides unconscious resistances and other factors leading to neurotic symptomatology in writing, it discusses parapraxes, a subject which fascinated the author and which he delighted to discuss, both in conversation and formal writing. The translation is by the author's older son, Walter Federn, of New York City, whose own research specialty is Egyptology, a subject in which he is a recognized authority.

ELSE B. KRIS, M.A., M.D. Following graduation from Vienna University Medical School, Dr. Kris received her psychiatric training under Professors Wagner-Jauregg and Sigmund Freud. She came to the United States in 1940 and served from 1942 to 1955 on the staff of Pilgrim State Hospital.

During this time she studied sociology at Adelphi College where she received her master's degree. Since 1955 she has headed the research unit set up at the Manhattan Aftercare Clinic in New York City, with the title of principal research scientist. This unit is now studying various problems in connection with chemotherapy in the aftercare of mental patients. At present, under a grant from the United States Department of Health, Education and Welfare, Office of Vocational Rehabilitation

a study is being conducted at the unit on the socio-economic rehabilitation of former mental patients. Since 1955, Dr. Kris has been on the faculty of Adelphi College where she is now professor of social psychiatry and associate director of research.

DONALD M. CARMICHAEL, M.D. Dr. Carmichael is director of aftercare clinics in New York City for the New York State Department of Mental Hygiene.

Born in Peterboro, Canada, he received his medical degree at Queens University in 1926. He did postgraduate work in psychiatry and psychoanalysis at the Columbia-Presbyterian Medical Center and the New York Psychoanalytic Institute. He served at Kings Park (N.Y.) State Hospital and Pilgrim (N.Y.) State Hospital from 1931 to 1943 and was clinical director at Harlem Valley (N.Y.) State Hospital from 1943 to 1947, and clinical director and associate director at Rockland (N.Y.) State Hospital from 1947 to 1954.

He is certified in psychiatry by the American Board of Psychiatry and Neurology, is a member of the American Medical Association, a fellow of the American Psychiatric Association and the American Group Psychotherapy Association, the New York Society of Clinical Psychiatry, the New York Academy of Sciences, and the American Association for the Advancement of Science. He is also a member of the American Psychiatric Association committee on rehabilitation. Since 1954 he has been director of the New York State Department of Mental Hygiene's aftercare clinics in New York City.

THOMAS I. HOEN, M.D. Dr. Hoen is a New York City neurosurgeon. A graduate in medicine of Johns Hopkins in 1928, he is a diplomate of the American Board of Neurological Surgery. Dr. Hoen was trained in neurosurgery under Harvey Cushing in Boston and Wilder Penfield in Montreal. He then served as chief of neurology and neurosurgical service at St. Luke's Hospital, Montreal. Following service at other hospitals in Canada, New Jersey and Connecticut, he moved to New York. He is professor and chairman of the department of neurosurgery at the New York University-Bellevue Medical Center. He is a captain in the inactive reserve of the navy and is a consultant in neurosurgery for various institutions in the New York area. He is director of neurosurgery, fourth division, Bellevue Hospital, and attending neurosurgeon at Central Islip (N.Y.) State Hospital.

ALDO MORELLO, M.D. Dr. Morello is a neurosurgeon now in practice at Palermo, Italy, where he is assistant professor in neuropsychiatry at the University of Palermo, of which he is a graduate in medicine. Born in Italy in 1927, he came to the United States in 1953 as a Fulbright fellow, to serve a residency in neurosurgery at the New York University-Bellevue Medical Center on the service of Dr. Thomas I. Hoen. Later he was assigned for three years of research at Central Islip State Hospital where he was instrumental in developing methods of neuroradiological diagnosis for neurosurgical techniques. He is a diplomate of the American Board of Neurosurgery and is the author of a number of scientific publications on neurology and neurosurgery, including a previous contribution to this QUARTERLY.

FRANCIS J. O'NEILL, M.D. Dr. O'Neill has been senior director of Central Islip State Hospital since 1951. Born in Vermont, he is a graduate of the University of Vermont, and of the University of Vermont College of Medicine, where he received his medical degree in 1932. After interning at an army general hospital and a short period in private practice, he joined the New York State hospital service as a medical intern at Central Islip in 1933. Except for World War II service in the navy as lieutenant, lieutenant-commander and commander, including service with the marine corps in the southwest Pacific, he has been with the New York State hospital system ever since he first joined it. He had served as psychiatrist in various grades and as pathologist before becoming director of Utica State Hospital in 1949. He was promoted to the senior directorship at Central Islip two years later. Dr. O'Neill is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, a member of the American Psychiatric Association and a fellow of the American Medical Association and of the American Society of Clinical Pathologists.

D. EWEN CAMERON, M.D., F.R.C.P.(C.) Since 1943, Dr. Cameron has been professor of psychiatry and chairman of the department of psychiatry at McGill University; psychiatrist-in-chief of the Royal Victoria Hospital; and director of the Allan Memorial Institute of Montreal. Born at Bridge of Allan, Scotland, in 1901, Dr. Cameron received his M.B., Ch.B. from the University of Glasgow in 1924 (with the degree of M.D. with distinction granted by the same university in 1936). Admitted to practice in Great Britain in 1924, he received his diploma in psychological medicine in 1925 from the University of London. From 1924 to 1926, Dr. Cameron held residencies at Glasgow and then served as assistant physician under Professor D. K. Henderson at Glasgow Royal Mental Hospital. He then held a two-year research scholarship at Phipps Clinic, the Johns

Hopkins Hospital, Baltimore, then studied in Zurich before going to Canada in 1929. From 1936 to 1938, he was at Worcester (Mass.) State Hospital as senior research psychiatrist and then resident director; from 1938 to 1943, was professor of neurology and psychiatry at Albany Medical College and neurologist and psychiatrist-in-chief at Albany Hospital.

Dr. Cameron returned to Canada in 1943 to head the Allan Memorial Institute. Dr. Cameron is a member of the British Medical Association and the Royal Medico-Psychological Association; a fellow and past president of the American Psychiatric Association; a fellow of the Royal College of Physicians and Surgeons of Canada; and a member of numerous other scientific organizations in both the United States and Canada. Dr. Cameron is the author of three scientific books and one on mental hygiene, and of approximately 100 scientific articles, including a number of previous publications in this QUARTERLY.

SIMON H. NAGLER, M.D. Dr. Nagler is a psychiatrist and psychoanalyst in private practice in New York City. A graduate of Temple University School of Medicine in 1935, he was a resident at the New York State Psychiatric Institute in 1942. He served as an army air force neuropsychiatrist from 1943 to 1946, and, in 1947, became a resident at Bellevue Hospital Psychiatric Division, New York City. He received his certificate in psychiatry from the American Board of Psychiatry and Neurology in 1947 and, that same year, entered the postgraduate comprehensive course in psychoanalysis at New York Medical College, completing it in 1950. He was assistant psychiatrist from 1950 to 1956 at Flower and Fifth Avenue Hospitals, and has since been assistant attending psychiatrist. He is now a member of the faculty of the postgraduate course in psychiatry at New York Medical College, is a fellow of the Academy of Psychoanalysis, and a member of the Society of Medical Psychoanalysts, New York City. He is a member of the American Psychiatric Association.

"BOOTS." "Boots'" article in this issue of THE QUARTERLY tells more about the author than can be compressed into a short biographical note. His description of himself as a homosexual boot-fetishist is not only included in his paper, but has been repeated numerous times in the course of considerable correspondence relating to that article. He tells the editors that he is 44 years old and has always lived in rural areas. THE QUARTERLY naturally cannot "guarantee" the accuracy of this biographical note or the authenticity of "Boots'" article; but if the article were not authentic, it would still be worth publication as the most convincing and most elaborate simulation of psychopathology the editors have ever encountered.

HAROLD BOURNE, M.B.B.S. (London), M.R.C.S., L.R.C.P., D.P.M. Dr. Bourne is Lecturer in Psychiatry at New Zealand's Medical School. His publications include research on psychogenic factors in mental defect with a syndrome he calls protophrenia, on convulsion dependence, and rational convulsion therapy. Recently the Australasian Association of Psychiatrists awarded the Evan Jones Prize to him for his contributions.

MOSES ZLOTLOW, M.D. Dr. Zlotlow, born in Poland in 1906, received his M.D. from the Medical School at Bari, Italy, in 1935. During World War II, from 1942 to 1945, he was in various German concentration camps. In 1946, he came to the United States and, after internship, joined the Pilgrim (N.Y.) State Hospital staff in 1949. At present, he is a supervising psychiatrist at Pilgrim and is on the neurological staffs at Bellevue Hospital and at Beth Israel Hospital. He is a member of the American Psychiatric Association and the Long Island Psychiatric Society.

ALBERT E. PAGANINI, M.D. Born in Brooklyn in 1920, Dr. Paganini received his B.S. from St. Francis College in Brooklyn in 1941, and his M.D. from Georgetown University School of Medicine in 1944. He had a rotating internship at St. Catherine's Hospital, Brooklyn, and St. Vincent's Hospital, Staten Island, then was in private general practice from 1947 to 1951. He was in military service during the Korean War from 1951 to 1953, in which time his interest and training in psychiatry began. He has been at Pilgrim (N.Y.) State Hospital since 1953. At present he is a supervising psychiatrist. Dr. Paganini is a member of the American Psychiatric Association, the Long Island Psychiatric Society and other professional organizations.

NEWS AND COMMENT

CLARK RECEIVES STATUE OF FREUD

A life-size bronze statue of Sigmund Freud, the work of the Jugoslav sculptor, Olem Nemon, was presented to Clark University, Worcester, Mass., on September 21, 1957 at a convocation in honor of Freud's lecture at Clark 48 years previously. Miss Anna Freud, youngest daughter of the founder of psychoanalysis and a specialist in ego psychology and in child psychology, was guest of honor at the symposium.

The statue was the gift of the American Psychoanalytic Association. It was unveiled in New York in 1947 and for 10 years was displayed about the country at various psychoanalytic meetings. Rudolph M. Loewenstein, M.D., president of the American Psychoanalytic Association, made the presentation. Anna Freud was in Worcester, not only for the Clark University ceremony but for a two-day symposium on child psychology on the thirty-fifth anniversary of the Child Guidance Association of Worcester.

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PRICES ARE INCREASED BY STATE HOSPITALS PRESS

In line with price increases previously announced for THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT, price increases have been put into effect for books, monographs and other printing in general by the State Hospitals Press, Utica, N. Y. Of particular importance to readers of this journal, are rises in the prices of *A Rorschach Training Manual,* by Brussel, Hitch and Piotrowski, which is now selling at $1.00; *A Psychiatric Word Book,* by Hutchings, now $2.25; and *Social and Biological Aspects of Mental Disease,* by Malzberg, now $2.50. The new prices are carried in the advertisements in this issue. Another publication in frequent demand is *Outlines for Psychiatric Examinations* by Nolan D. C. Lewis, M.D. This is now $2.00 cloth, $1.50 paper. Readers interested in other State Hospitals Press publications are advised to address inquiries to: The State Hospitals Press, 1213 Court Street, Utica, N.Y. A full price list will be mailed on request.

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DR. SAL y ROSAS HEADS EPILEPSY LEAGUE

The Peruvian League to Fight Against Epilepsy has asked the QUARTERLY to make note of the election of its board of directors at its first annual meeting in Lima. Dr. Federico Sal y Rosas was elected president, with 11 other members of the governing board. The directors plan a program to encourage an exchange of ideas and efforts among other persons interested in the medical and social problems of epilepsy.

MERRILL MOORE, M.D., PSYCHOANALYST AND POET, DIES

Merrill Moore, M.D., psychoanalyst and poet, died at his home in Squantum, Mass., on September 20, 1957, after a short illness. Born in Tennessee in 1903, he received his medical degree from Vanderbilt University in 1928. After an internship, he served as resident and as house officer in general medicine and neurology at Boston City Hospital, then was assistant physician and Commonwealth fellow at Boston Psychopathic Hospital. In recent years, he had been in the private practice of psychiatry and psychoanalysis in Boston and had held numerous visiting and consulting positions in neurology and psychiatry there.

Although literary critics held that Dr. Moore had become a rather thorough Bostonian, his writings first attracted attention when he was a member of a group of young Southern literary people in college and shortly afterward. Besides scientific writings, his purely literary output was such that it seemed doubtful to critics—a matter reviewers have commented on, specifically in this QUARTERLY—whether he was a poet who was also a psychoanalyst or a psychoanalyst who was also a poet.

Dr. Moore was the author of numerous volumes of verse, most of them reflecting an analyst's view of life and of personalities. His chosen verse form was the sonnet in all its recognized forms from Petrarch to Spencer, with personal variations which included disregard of the basic requirement of 14 lines but generally preserved the unity and essential spirit of that verse form. His verse output was prodigious, and his most recent volume, *The Hill of Venus*—made up of his own type of sonnet, as usual—was reviewed in the July 1957 issue of this QUARTERLY. Other books of verse included *Clinical Sonnets, More Clinical Sonnets, Illegitimate Sonnets,* and *Case Record from a Sonnetorium.*

Dr. Moore was also the author of a number of scientific papers; and he held numerous visiting and consulting positions, as both a neurologist and psychiatrist; he was certified in both specialties by the American Board of Psychiatry and Neurology. He was director of research at the Washingtonian Hospital and clinical associate psychiatrist at Harvard. During World War II, he served as a colonel in the army medical corps in the southwest Pacific, receiving the Bronze Star, Bougainville, in 1944 and the Army Commendation Ribbon, Nanking, 1946. Dr. Moore was a fellow of the American Psychiatric Association, and a member of the American Neurological Association and other professional organizations.

$60,000 ROCKEFELLER GRANT ANNOUNCED

Jack R. Ewalt, M.D., director of the Joint Commission on Mental Illness and Health, has announced receipt of a $60,000 grant from the Rockefeller Brothers Fund to further its three-year survey of American mental health

needs and resources. The contribution, says Dr. Ewalt, will be used to help finance a study, now at the planning stage, of the role of religion in mental health. The study is expected to be finished early in 1959 and will concern two broad areas: the church as an important mental health resource; and religious belief or faith as a source of mental health or illness.

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WILLIAM C. SANDY, M.D., PSYCHIATRIST, DIES AT 80

William C. Sandy, M.D., director of the bureau of mental health, Pennsylvania Department of Welfare for 23 years before his retirement in 1944, died after a short illness in Geneva General Hospital, Geneva, N. Y., on September 7, 1957, two days before his eighty-first birthday. Dr. Sandy, born in Troy, N. Y., was a graduate of Columbia College and received his M.D. from the College of Physicians and Surgeons, Columbia University, in 1901. He served in mental institutions in New Jersey, New York, South Carolina and Connecticut before going to Pennsylvania. He was in the army medical corps during World War I. Dr. Sandy was president of the American Psychiatric Association in 1939-40 and was a member of numerous other professional groups. He had served as associate editor of the *American Journal of Psychiatry* and was the author of numerous scientific articles.

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MEETINGS AND ANNOUNCEMENTS FOR 1958

The American Orthopsychiatric Association will conduct its thirty-sixth annual meeting March 6, 7, and 8, 1958 in New York City, with more than 5,000 psychiatrists, psychologists and other specialists in the behaviorial sciences expected to attend. Dr. Marion F. Langer, executive secretary, announces that arrangements are also being made for attendance by non-members. Dr. Reginald S. Lourie, president of the Association, will address an opening session March 6. More than 60 scientific papers are expected to be presented on subjects ranging from crime to the teacher's role in mental health.

The second meeting of a new international association, the International Collegium for Neuro-Psychopharmacology, will be conducted in Rome, Italy, September 9 to 12, 1958. Investigators from 13 different countries founded the collegium at the Second International Congress for Psychiatry in Zurich in September 1957. Professor E. Rothlin of Switzerland is president. Dr. Herman C. B. Denber of Manhattan (N.Y.) State Hospital, representing the United States, is a member of the executive committee as a secretary. Dr. Denber requests that those interested in presenting papers send 250-word abstracts to him at Manhattan State Hospital.

Another international undertaking, this one proposed for 1960 and

1961, was planned at the annual meeting in Copenhagen last summer of the World Federation for Mental Health. The period from January 1, 1960 through June 30, 1961 will be designated as the first World Mental Health Year. It will culminate in the Fifth International Congress on Mental Health in Paris in October 1961. Dr. Frank Fremont-Smith of the United States is chairman of the planning committee for the mental health year.

The National Training Laboratories have announced that their twelfth annual summer National Training Laboratory in group development will be conducted at Gould Academy, Bethel, Maine for two three-week sessions during the summer of 1958. The first session will be from June 15 to July 4, and the second from July 13 to August 1. There will be 150 persons admitted to each session.

The Association for the Advancement of Psychoanalysis announces the Sixth Annual Karen Horney Lecture to be given by Dr. Abraham Kardiner on "New Horizons and Responsibilities of Psychoanalysis." The meeting will be held on Wednesday, March 26, 1958, at 8:30 P.M. at the New York Academy of Medicine, and a dinner honoring the guest speaker will precede the lecture.

A new children's psychiatric service has been announced by the department of psychiatry of the University of North Carolina to open February 1, 1958. It will be a nine-bed inpatient service in the North Carolina Memorial Hospital, and children from other states may be referred as private patients. The service will be for intensive diagnostic evaluation and short-term therapy of emotionally disturbed children under 12.

The sixth and seventh lectures of the Eighth Annual North Shore Hospital lecture series will be held at the hospital in Winnetka, Ill. on March 5 and April 2, with Professor B. Cramer, M.D., and Joseph J. Michaels, M.D., as speakers. Dr. Cramer will discuss "Management of Social Adjustment and Behavior Problems in Adolescence," and Dr. Michaels' topic will be "Management of the Delinquent."

Four six-week courses of intensive training in the problems of mental deficiency are being offered, tuition free, by the New York State Department of Mental Hygiene to physicians throughout the United States who have completed internships and six months of residency. The first course will be opened the first Monday in February 1958; the second, the third Monday in March; the third, the third Monday in September, and the fourth, the first Monday in November. Each session will be limited to 10 students; and all must be graduates of approved medical colleges and endorsed by the directors of their residency centers.

RABBI JOSHUA BLOCH, HOSPITAL CHAPLAIN, DIES AT 67

The Reverend Joshua Bloch, rabbi, librarian, author and chaplain of Creedmoor (N.Y.) State Hospital, Queens Village, N. Y., died at the hospital of a heart attack on September 26, 1957. He had gone there to preach the Rosh ha-Shanah sermon. Born in Lithuania, Dr. Bloch had attended Dropsie College, Hebrew Union College, the University of Cincinnati, Columbia University, the Jewish Theological Seminary and New York University. He had a Ph.D. from New York University and an honorary D.D. from Hebrew Union College. For 33 years Dr. Bloch had been chief of the Jewish division of the New York Public Library. He was a contributor to various important theological and general reference works, was the author of a book, *On the Apocalyptic in Judaism*, and was well known for his work in the cause of mental hygiene.

PSYCHOPHARMACOLOGICAL CLEARING HOUSE SET UP

The Psychopharmacological Service Center of the National Institute of Mental Health has announced the establishment of a clearing house of information on psychopharmacology. The clearing house seeks to make a collection of the literature, including pharmacological, clinical, behavioral and experimental studies of the ataractic (or phrenopraxic) psychotomimetic and other centrally-acting drugs. These are to be classified and coded to enable the answering of questions. The center is inviting workers to provide three copies of any papers on this subject—reprints, pre-publication manuscripts, progress reports, papers read at meetings, abstracts, etc. Any restrictions placed on the use of such papers will be observed. Material should be addressed to the Technical Information Unit, Psychopharmacological Service Center, National Institute of Mental Health, 8759 Colesville Road, Silver Spring, Md.

HOFHEIMER PRIZE DATES ANNOUNCED

The next annual award of The Hofheimer Prize of $1,500—given annually by the American Psychiatric Association for an outstanding research contribution in the field of psychiatry or mental hygiene which has been published within three years of the date of the award—will be made at the annual meeting of the American Psychiatric Association in May 1958. The competition is open to citizens of the United States and Canada not over 40 years of age at the time the article was submitted for publication; or to a group whose median ages do not exceed 40. Articles submitted to the Prize Board before March 1, 1958 will be considered. Eight copies of each publication and data concerning age and citizenship should be sent to John I. Nurnberger, M.D., Chairman, Hofheimer Prize Board, 1100 W. Michigan St., Indianapolis 7, Indiana.

JOURNAL FOUNDED TO AID FORMER PATIENTS

A non-profit, voluntary, mimeographed, international magazine and information center has been founded to aid former mental patients. The project called *SEARCH*, is directed by Bill Moore, author of *The Mind in Chains*. He does the editing and most of the correspondence in his spare time. His wife operates the mimeograph machine and their children help assemble and bind the booklets. SEARCH is stressing social approaches to mental health: halfway houses, foster home care, open doors in hospitals, libraries and educational therapy, work for pay for inpatients and numerous other activities. Mr. Moore says that the journal, starting with a $35 loan, would not have survived without help from the medical profession. A hospital director who does not wish to be named has offered to pay for cutting stencils for a year. Dr. Walter C. Alvarez has promoted the project in his syndicated medical column, and inquiries and subscriptions have been received from numerous Veterans Administration and state hospitals as well as former patients and mental health groups. The magazine is issued about every month and a half, with the subscription rate $1.00 for five issues. There is an effort at present to raise funds to send it to every patient library of every state hospital and every Veterans Administration hospital in the country. The journal's address is: Franklin Street, MR 98, Binghamton, N. Y. Its name is made up from the initial letters of service, education, action, responsibility, character and health.

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KAREN HORNEY AWARD ESTABLISHED

The Association for the Advancement of Psychoanalysis announces the establishment of an annual $150 award for an author whose paper makes an outstanding contribution to the development of psychoanalysis. Papers submitted by May 30, 1958 will be judged in time for the award on December 30, 1958, and the accepted paper will be published in *The American Journal of Psychoanalysis*. The association asks that entries be forwarded to Louis E. DeRosis, M.D., Chairman, Award Committee, 815 Park Avenue, New York 21, N. Y.

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WESTERN NEW YORK SOCIETY RECOGNIZED

The QUARTERLY has been asked to note that the Western New York Psychiatric Society has been officially accepted as a district branch of the American Psychiatric Association. Its announcement lists its present membership at 31. Dr. Evelyn Alpern is president and Dr. Duncan Whitehead, senior associate editor of this journal and director of Buffalo (N.Y.) State Hospital, is vice-president.

NEW SERVICES FOR HANDICAPPED CHILDREN

The Child Study, Treatment and Research Center of The Woods Schools, Langhorne, Pa., has been opened following dedication ceremonies on October 12, 1957. First of its kind in the country, the center is affiliated with three universities, Columbia, Rutgers and University of Pennsylvania, as well as with Children's Hospital of Philadelphia and the Philadelphia Child Guidance Clinic. Dr. William C. Adamson, child psychiatrist, heads the resident staff of medical, psychologic, and social work personnel.

The center's services are available not only to children of The Woods Schools but to all others who can be accommodated on an outpatient basis. Arrangements have also been made to enroll boys and girls, aged nine to 18, with emotional difficulties, for a three-month to six-month period. Psychotherapy, speech, hearing and physical therapy as well as remedial reading are being offered. Special vocational training will be inaugurated next year.

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SEX SOCIETY ORGANIZATION ANNOUNCED

The Society for the Scientific Study of Sex (SSSS) has been organized for interdisciplinary exchange in the field of sex knowledge, and this journal has been asked by Hugo G. Beigel, Ph.D., associate professor of the department of psychology of Long Island University, to call the attention of readers to its foundation. The society has set minimum requirements for membership as a graduate degree or its equivalent in one of the biological or social sciences, plus contributions to sexual science; or significant contributions to sexual science. A doctor's degree, plus scientific contributions, is a minimum requirement for a fellow. The society's announcement says it will hold periodic scientific meetings for the presentation of research papers and will organize symposia, seminars, workshops and conferences to consider theoretical and practical problems in the area of sex. It is also to publish a scientific journal.

THE INDEX

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